

<b>Case Number:</b>	CM13-0066252		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	12/23/2011
<b>Decision Date:</b>	03/28/2014	<b>UR Denial Date:</b>	12/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 29-year-old male sustained a repetitive use right shoulder injury on 12/23/11 washing cars. The 12/15/12 right shoulder MRI showed minimal osteoarthritic changes in the acromioclavicular joint. Records documented 22 chiropractic visits from 4/30/12 to 7/20/12 with restoration of full shoulder range of motion, and 12 visits of physical therapy with improvement in strength. The 3/21/13 P&S report indicated that the right shoulder had substantially improved with residual slight discomfort with maximum above-shoulder-level activities. Exam findings documented full right shoulder range of motion, moderate weakness with all motions, and slightly positive impingement signs. Continued work restrictions were outlined. The 4/2/13 orthopedic report cited increasing (grade 8/10) shoulder pain and indicated that the patient was deconditioned. Medications (opioids, muscle relaxant, NSAID, and PPI) were prescribed. The 4/23/13 report noted a reduction in pain with medications, and the patient requested additional physical therapy for conditioning. A shoulder exercise kit was dispensed and medications were prescribed. Additional reports in April and May 2013 noted requests for 12 sessions of physical therapy but there was no indication that physical therapy was provided. There is a gap in records from 5/14/13 to 10/22/13. The 10/22/13 orthopedic report cited worsening grade 8/10 right shoulder pain with decreased tolerance of a variety of activities. Objective findings documented right anterior shoulder and AC tenderness, positive impingement signs, right shoulder abduction 90 degrees and forward flexion 90 degrees. The provider stated that the right shoulder condition was refractory to extensive conservative treatment including physical therapy, home exercise, and activity modification. A right shoulder arthroscopic subacromial decompression was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Right shoulder arthroscopic subacromial decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563, Postsurgical Treatment Guidelines Page(s): 27.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for Impingement Syndrome.

**Decision rationale:** The Physician Reviewer's decision rationale: Under consideration is a request for right shoulder arthroscopic subacromial decompression. The California MTUS guidelines do not address shoulder surgery for chronic injuries. The Official Disability Guidelines recommend arthroscopic decompression for shoulder impingement syndrome for patients who fail 3 to 6 months of conservative treatment, have positive impingement sign with a positive diagnostic injection test, and have positive clinical imaging findings of impingement. The 12/15/12 right shoulder MRI showed minimal AC joint arthrosis. Prior physical therapy and chiropractic treatment in 2012 is noted with subjective and functional improvement. There is no documentation that recent detailed comprehensive non-operative treatment, including injection, has been tried and failed. Given the failure to meet guideline criteria, the request for right shoulder subacromial decompression is not medically necessary.

**Post-op PT 3x4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563, Postsurgical Treatment Guidelines Page(s): 27.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** The Physician Reviewer's decision rationale: The right shoulder arthroscopic subacromial decompression is not medically necessary; therefore the request for post-op PT 3x4 is also not necessary.