

<b>Case Number:</b>	CM14-0167405		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	07/21/2014
<b>Decision Date:</b>	11/21/2014	<b>UR Denial Date:</b>	09/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in Texas. 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 expert 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:

The injured worker is a 54 year old male with a date of injury on 7/21/2014. He was employed as a spray painter. The injury occurred while grinding overhead for a whole shift. His medical history was positive for hypercholesterolemia and diabetes. The 8/1/14 Doctor's First Report documented constant right shoulder pain extending into the forearm and difficulty using his arm overhead. Medications included Ibuprofen. The physical exam documented tenderness over the subacromial bursa and rotator cuff, right shoulder. The bilateral shoulder range of motion testing documented essentially full right shoulder range of motion with no crepitus. There was marked pain with resisted abduction and painful arc of motion on the right. The grip strength was symmetrical at 105-110 pounds. The diagnosis was overuse syndrome right upper extremity with impingement syndrome right shoulder, rule-out rotator cuff tear. The treatment plan recommended right shoulder magnetic resonance imaging, Ibuprofen, and modified work. The 8/18/14 right shoulder magnetic resonance imaging impression documented mild supraspinatus tendinopathy with no discrete rotator cuff tear. There was moderate bone marrow edema and soft tissue edema around the acromioclavicular joint, inflammatory arthropathy could not be ruled-out. The 9/18/14 treating physician report cited right shoulder pain with temporary benefit with right shoulder injection. The physical exam documented decreased range of motion, positive impingement sign, and marked rotator cuff tenderness. The diagnosis was shoulder synovitis. The treatment plan documented an ultrasound-guided right shoulder corticosteroid injection. Authorization for right shoulder arthroscopy with subacromial decompression was requested. The injured worker was to return to modified work. The 9/25/14 utilization review denied the request for right shoulder arthroscopy based on an absence of conservative treatment consistent with guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy, SAD (Sub-Acromial Decompression): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Surgery for Impingement Syndrome

**Decision rationale:** The American College of Occupational and Environmental Medicine guidelines provide a general recommendation for impingement surgery. Surgery for impingement syndrome is usually arthroscopic decompression. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Additionally, the criteria include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. The guideline criteria have not been met. There is no clear imaging evidence of impingement. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.