

Case Number:	CM14-0053082		
Date Assigned:	07/07/2014	Date of Injury:	04/19/2012
Decision Date:	08/06/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	04/22/2014

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 Orthopedic 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 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 patient is a 64-year-old female office support specialist sustained an industrial injury on 4/19/02, due to repetitive work duties. The 3/21/14 right shoulder MRI impression documented acromioclavicular osteoarthritis, supraspinatus tendinitis, and infraspinatus tendinitis. The 3/21/14 left shoulder MRI impression documented complete tear of the supraspinatus tendon with 6 mm tendon retraction, infraspinatus tendinitis, and acromioclavicular osteoarthritis. Records indicated a right shoulder subacromial injection on 2/28/14 with a 75% reduction in shoulder and neck pain. The 3/28/14 treating physician report cited constant severe shoulder pain, aggravated by keyboarding, reaching, pushing, pulling, lifting, or carrying heavy objects. Pain is relieved by resting, heat, creams and therapy. Symptoms were significantly affecting activities of daily living. X-rays demonstrated a type II acromion bilaterally. Surgery was recommended as conservative treatment had failed. The treating physician indicated that despite the full thickness rotator cuff tear in the left shoulder, the right shoulder was limiting her the most. She would like to have the right shoulder addressed first. The treatment plan recommended right shoulder arthroscopic acromioplasty with distal claviclectomy. The 4/16/14 utilization review denied the request for right shoulder arthroscopy based on an absence of detailed conservative treatment and physical exam findings of impingement. The 4/25/14 orthopedic report indicated the shoulder complaints were unchanged. Physical exam findings documented anterior and periscapular tenderness, normal shoulder strength, positive Neer and Hawkin's impingement sign, positive cross chest test, and positive acromioclavicular joint compression test. Range of motion testing documented flexion 160, extension 40, abduction 170, adduction 40, external rotation 90, and internal rotation 55 degrees. The treatment plan recommended physical therapy three times a week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic acromioplasty with distal claviclectomy: 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): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome.

Decision rationale: The California MTUS guidelines provide a general recommendations for impingement surgery. 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. Criteria additionally 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. In this case, there is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Physical therapy has been reported as beneficial and additional therapy has been recommended. Muscle strength is normal. There was a slight loss of internal rotation motion with otherwise functional range of motion. There is no clear imaging evidence of impingement noted on the right shoulder MRI. Therefore, the request for right shoulder arthroscopic acromioplasty with distal claviclectomy is not medically necessary and appropriate.