MAXIMUS Federal Services

Case Number:	CM14-0054543		
Date Assigned:	07/09/2014	Date of Injury:	01/23/2012
Decision Date:	09/24/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	04/23/2014

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 Indiana. 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 member is a 38-year-old male who suffered an injury to his right shoulder at work as a laborer repetitively lifting and carrying automotive parts weighing up to 100 pounds as well as repetitive use of impact tools, prolonged periods of fine hand manipulation, torquing and lifting, and reaching above shoulder level. He has not worked since his termination from work on 1/1/13. He complains of worsening right shoulder pain, moderate to severe, described as stabbing. On 1/2/14 the member was noted on physical exam to have tenderness to the right biceps tendon, anterior subacromial, AC join, trapezius and deltoid with a positive Neer's test, normal motor strength and reflexes in the right upper extremity, and ROM equivalent to the left shoulder in all planes. On an exam performed on 1/13/14, the member was noted to have a positive impingement test with tenderness of the right AC joint and bicipital groove with right upper trapezius muscle tenderness with spasms. Conservative treatment has included prescriptions for flexeril, tramadol, and naproxen sodium. The member's complaints include frequent moderate throbbing pain with stiffness in the shoulders with swelling without discoloration of the right shoulder. He has noted a popping sensation in his shoulders. The member states that his right shoulder loses strength and feels inflamed. He first noticed his right shoulder symptoms in 2011. He has noted some relief with use of a muscle stimulator and medications. Right shoulder x-rays performed on 3/12/13 were intrepreted as negative. A CT of the right shoulder performed on 5/28/13 was interpreted as unremarkable. An MRI of the shoulder could not be performed on the member due to metal in the eye. An EMG/NCV of the upper extremities was reported as normal. On a 2/5/14 exam, the member complained on constant shoulder pain bilaterally, right greater than left, described as sharp and numbing with spasms, 4-6/10, and worse in the morning and evening. The member had a positive Neer and Hawkins-Kennedy tests with muscle testing 4/5 throughout in the right upper extremity with

slight limitation of measured ROM of the shoulder in all planes. A steroid injection of the right shoulder was performed on that date. The member has been diagnosed with bilateral shoulder subacromial subdeltoid bursitis with impingement. A request has been made for approval for right shoulder arthroscopic surgery due to the member's continued right shoulder pain complaints not responsive to conservative treatment including PT, chiropractic care, acupuncture, NSAIDs, and a steroid injection. The treating physician is requesting approval for a right shoulder arthroscopy/subacromial decompression since the claimant's right shoulder is still symptomatic despite conservative treatment and is also requesting pre-op medical clearance, post-op physical therapy, a post-op shoulder sling and the purchase of a cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy ,subacromial decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3, Shoulder, Surgical Considerations, Impingement Syndrome.

Decision rationale: According to the ACOEM V.3 Guidelines for the shoulder, surgical indications, Impingement syndrome:Recommendation: Subacromial Decompression Surgery for Impingement Syndrome/Rotator Cuff Tendinoses Subacromial decompression surgery is recommended for treatment of select patients with impingement syndrome/rotator cuff tendinoses.Indications - All of the following: 1) shoulder joint pain (e.g., symptomatic with positive supraspinatus test, impingement signs); 2) reduced active shoulder ROM or impaired function 3) imaging findings by MRI or ultrasound of rotator cuff tendinoses consistent with symptoms; and 4) temporary resolution or marked reduction in pain immediately after injection of a local anesthetic into the subacromial space. Patients should also have failed one or more glucocorticosteroid injections (see above) and at least one trial of a quality rehabilitation program that follows evidence-based guidelines (see above).(105-107, 413, 415, 447, 761, 806, 846)The member does have right shoulder joint pain with positive impingement signs (Neer and Hawkins-Kennedy tests) with reduced active ROM and impaired function, but does not have positive imaging studies such as an ultrasound consistent with a rotator cuff tendinosis and does not have documentation of a marked reduction in pain immediately after injection of a local anesthetic into the subacromial space. Since the member does not meet all the criteria for subacromial decompression surgery for impingement syndrome/rotator cuff tendinoses, the requested medical treatment is not medically necessary.

Pre-medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3, Shoulder, Surgical Considerations, Impingement Syndrome.

Decision rationale: Since the member does not meet all the criteria for subacromial decompression surgery for impingement syndrome/rotator cuff tendinoses according to the ACOEM V.3 guidelines for shoulder surgical indications for impingement syndrome, a pre-medical clearance is not medically necessary.

Post op physical therapy 3x4 for right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3, Shoulder, Surgical Considerations, Impingement Syndrome.

Decision rationale: Since the member does not meet all the criteria for subacromial decompression surgery for impingement syndrome/rotator cuff tendinoses according to the ACOEM V.3 guidelines for shoulder surgical indications for impingement syndrome, post-op physical therapy 3x4 for the right shoulder is not medically necessary.

Right shoulder sling: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3, Shoulder, Surgical Considerations, Impingement Syndrome.

Decision rationale: Since the member does not meet all the criteria for subacromial decompression surgery for impingement syndrome/rotator cuff tendinoses according to the ACOEM V.3 guidelines for shoulder surgical indications for impingement syndrome, a right shoulder sling is not medically necessary.

Purchase of cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3, Shoulder, Surgical Considerations, Impingement Syndrome.

Decision rationale: Since the member does not meet all the criteria for subacromial decompression surgery for impingement syndrome/rotator cuff tendinoses according to the ACOEM V.3 guidelines for shoulder surgical indications for impingement syndrome, the purchase of a cold therapy unit is not medically necessary.