

Case Number:	CM14-0191491		
Date Assigned:	11/24/2014	Date of Injury:	07/25/2003
Decision Date:	12/07/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/14/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 63-year-old male who sustained an industrial injury on 7/25/03. The mechanism of injury was not documented. Occupational history was not documented. The 2/7/14 treating physician reports cited recurrent left shoulder pain and difficulty with repetitive overhead activities. He had a left shoulder corticosteroid injection and was performing a home exercise program. He was using Norco for pain at night. Physical exam documented left shoulder range of motion as forward elevation 140 degrees, external rotation 30 degrees, and internal rotation to L5/S1. Left shoulder exam documented posterior capsule tightness, external rotation 5/5, infraspinatus lag test 5/5, and supraspinatus test 4+/5. He had positive impingement signs 1, 2, and 3, Speed's, and Yergason's tests. A recent MRI had been obtained with evidence of left shoulder impingement with bursitis and acromial spurring. The injured worker had rather significant acromial spurring that had re-grown since his left shoulder acromioplasty many years ago. He had clinical exam findings of impingement and had failed conservative management. Surgery was recommended. The 4/14/14 treating physician report noted denial of the request for left shoulder surgery. The injured worker had continued left shoulder pain reaching out to the side and with above shoulder height activity. Physical exam documented mild left shoulder atrophy, marked crepitus, limited range of motion, 4-/5 supraspinatus strength, and positive impingement signs. The injured worker had undergone corticosteroid injection, formal physical therapy, and a home exercise program with only short term relief. Surgery was again recommended. He was able to work his usual and customary job. The 10/1/14 orthopedic surgery report indicated that the injured worker had recurrent left shoulder pain. He had pain with

reaching and overhead activities, and at night. Physical exam documented forward elevation to 140 degrees, external rotation 30 degrees and internal rotation to L5. In 90 degrees of rotation, he could externally rotate 45 degrees and internally rotate 20 degrees with pain. He had markedly positive impingement signs 1, 2, and 3. Previous radiographs were reviewed and showed evidence of anterior-inferior acromial spurring which was prominent on both the Y view and 30-degree caudal tilt view. The diagnosis included left shoulder impingement and cuff tendinopathy. The injured worker had failed conservative management of corticosteroid injection and physical therapy. Authorization was requested for outpatient left shoulder arthroscopic acromioplasty surgery and 12 initial post-operative physical therapy sessions. The 11/3/14 utilization review non-certified the request for the outpatient left arthroscopic acromioplasty and associated post-op physical therapy as the injured worker was working without restrictions, had normal rotator cuff strength, and there was an uncertain history of previous surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic Arcromioplasty surgery to the left shoulder as outpatient: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery and rotator cuff surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome 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, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement. Guideline criteria have been met. This injured worker presented with recurrent left shoulder pain with difficulty reaching out and performing above shoulder height activities. He had pain at night. Clinical exam findings were consistent with reported imaging evidence of impingement. The treating physician reported that significant acromial spurring had re-grown since a remote prior acromioplasty procedure. There was documentation of a positive diagnostic injection test. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure had been submitted. Therefore, this request is medically necessary.

12 initial post-operative physical therapy, 2x a week for 6 weeks for the left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s):
Shoulder.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for impingement syndrome suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the post-surgical physical medicine period. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.