

Case Number:	CM15-0004698		
Date Assigned:	01/15/2015	Date of Injury:	11/12/2012
Decision Date:	03/24/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/09/2015

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:

The injured worker is a 46-year-old male who sustained an industrial injury on 11/12/2012. Past surgical history was positive for left shoulder labral repair, subacromial decompression, and debridement on 3/13/13, and left shoulder intra-articular debridement and distal clavicle resection on 12/30/13. The 4/15/14 left shoulder MRI showed prior labral tear status post repair with suture anchors. There was a tear of the anterior superior labrum, low grade articular sided irregularity of the supraspinatus and infraspinatus tendons at their insertion on the greater tuberosity, and interval Mumford procedure. Conservative treatment included activity modification, anti-inflammatory medication, injections, and 16 post-op physical therapy sessions. The 11/4/14 treating physician report cited intractable shoulder pain that had failed conservative treatment. Injection on 9/22/14 relieved symptoms completely for one day. Shoulder exam documented anterior tenderness over the subacromial and bicipital groove, and range of motion limited to flexion 155, extension 35, abduction 140, adduction 25, external rotation 55, and internal rotation 60 degrees. There was a painful arc of motion, and positive Neer's, Hawkin's, O'Brien's, and Yergason's tests. The patient had a transient ischemic attack on 7/10/14 with residual coordination issues in the left upper extremity. The treatment plan requested left shoulder arthroscopic acromioplasty and possible biceps tenodesis. The 12/01/2014 treating physician report cited constant moderate to severe left shoulder pain with profound limitations. Associated symptoms included weakness and waking up at night. The patient was unable to return to work. X-rays showed good glenohumeral relationship, type III acromion, cystic area at the level of the greater tuberosity, and wide acromioclavicular joint

resection. The diagnoses included left shoulder impingement syndrome, status post SLAP repair and distal claviclectomy, and arthritis. The treatment plan requested left shoulder arthroscopic acromioplasty and possible biceps tenodesis. On 12/18/14, Utilization Review non-certified the request for left shoulder arthroscopic acromioplasty noting there were no focal examination findings included with this request. Additionally, there is no prior failure of an injection. ACOEM and ODG were cited. On 1/09/15, the injured worker submitted a request for IMR review of the left shoulder arthroscopic acromioplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic acromioplasty: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG Shoulder Indications for surgery - Acromioplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Shoulder: Surgery for impingement syndrome; Acromioplasty

Decision rationale: The California MTUS guidelines provide a general recommendation 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. Guideline criteria have been met. This patient presents with moderate to severe right shoulder pain and significant limitations precluding return to work and limiting activities of daily living. Signs/symptoms and clinical exam findings are consistent with radiographic evidence of plausible impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment, protocol trial, including injection, and failure has been submitted. Therefore, this request is medically necessary.