

Case Number:	CM15-0081473		
Date Assigned:	05/04/2015	Date of Injury:	03/01/2014
Decision Date:	07/27/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	04/28/2015

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:

This injured worker is a 36-year-old female who sustained an industrial injury on 3/01/14, relative to repetitive work activities. The 5/14/14 right shoulder MRI revealed right shoulder supraspinatus tendinosis versus interstitial partial tear with subcortical cyst in the humeral head. Records documented a right shoulder corticosteroid injection on 6/20/14 with some relief. Conservative treatment had included medications, activity modification, and physical therapy. The 1/27/15 treating physician report cited progressive right shoulder pain with limited range of motion and positive impingement signs. The right shoulder MRI was again reviewed and demonstrated significant supraspinatus tendinosis with partial tearing and subcortical cysts in the humeral head. She had an injection with only temporary impingement and her symptoms have gotten progressive worse, particularly nocturnally. Authorization was requested for right shoulder arthroscopic subacromial decompression. The 3/2/15 treating physician report cited grade 7/10 worsening right shoulder pain with decline in activity and function noted. Right shoulder exam documented forward flexion and abduction to 90 degrees, crepitance with motion, tenderness over the right anterior shoulder and over the acromioclavicular joint, and positive impingement signs. The diagnosis included right shoulder chronic impingement, rule-out rotator cuff pathology. Right shoulder arthroscopic subacromial decompression had been recommended, an updated right shoulder MRI was requested. Authorization was requested for right shoulder arthroscopic subacromial decompression and 12 sessions of postoperative physical therapy for the right shoulder. The 4/7/15 utilization review non-certified the right shoulder arthroscopic subacromial decompression and post-op physical therapy as there was no documentation of recent MRI findings and shoulder physical exam was incomplete.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic subacromial decompression: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Indications for Surgery, Rotator cuff repair.

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: Surgery for Impingement syndrome.

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. 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 presents with persistent and function-limiting right shoulder pain. Clinical exam findings are consistent with imaging evidence of rotator cuff pathology and plausible impingement. A diagnostic injection test was positive. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

12 sessions of post-operative physical therapy for the right shoulder: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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. If it is determined 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 postsurgical physical medicine period. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.