

Case Number:	CM14-0123433		
Date Assigned:	09/16/2014	Date of Injury:	04/15/2013
Decision Date:	10/20/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/04/2014

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:

This 56-year-old male machine operator sustained an industrial injury on 4/15/13. Injury was sustained in a chemical explosion that occurred about 2 feet in front of the patient. The patient was knocked down onto his right shoulder. The 9/15/13 right shoulder MRI revealed a high-grade partial thickness supraspinatus tear, type 2 acromion, and acromioclavicular joint arthropathy. The 4/25/14 PQME report indicated that patient had worsening grade 9/10 right shoulder pain with weakness and significant functional limitation. The patient had been treated with medications, physical therapy, and subacromial injection without relief. Physical exam documented positive right impingement test and internal rotation decreased by 50%. Right shoulder abduction was 70 degrees and flexion 90 degrees. External rotation was full. The treatment plan recommended referral to an orthopedic surgeon for evaluation. The patient underwent right shoulder subacromial decompression on 6/24/14. The 7/17/14 utilization review denied the retrospective surgical request as there were no pre-surgical exam findings documented and conservative treatment was not fully detailed. The 9/23/14 treating physician appeal reported that the patient was referred on 3/5/14 for right shoulder pain that woke him at night and pain with overhead activities. Functional limitation was noted in dressing. Physical exam documented positive Neer impingement sign, supraspinatus isolation sign, and Hawkin's test. MRI findings were consistent with right shoulder impingement with partial rotator cuff tear. The patient had persistent and bothersome right shoulder pain despite eleven months of at least intermittent conservative treatment. He had 6 visits of physical therapy and two corticosteroid injections with no significant improvement. Operative findings confirmed a great amount of subacromial bursitis with spurs in the anterolateral and undersurface of the acromion. The biceps tendon, superior labrum, and anterior and inferior labrum were intact. The joint cartilage was intact throughout the glenoid and humeral head surfaces. The middle glenohumeral ligament was intact. The

rotator cuff was well attached to the greater tuberosity without any evidence of joint sided tearing. Retrospective authorization of the right shoulder surgery was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective outpatient right shoulder subacromial decompression (SAD), date of service 6/24/14: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG SAD, ODG 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 Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome

Decision rationale: The California MTUS guidelines provide general recommendations for impingement syndrome. For rotator cuff tears presenting primarily as impingement, surgery is reserved for cases failing conservative treatment for three months. The preferred procedure is arthroscopic decompression. 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 presented with subjective and clinical exam findings consistent with imaging evidence of impingement. Evidence of 11 months of a reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is medically necessary.