

<b>Case Number:</b>	CM14-0127573		
<b>Date Assigned:</b>	08/15/2014	<b>Date of Injury:</b>	09/27/2011
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	07/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/11/2014

### 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:

The patient is a 52 year old female who sustained an industrial injury on 9/27/2011. According to the 4/9/2014 QME report, the patient's history of treatment had been fragmented, and she had not obtained any treatment in almost 1 year. Examination was classic for impingement syndrome. The QME does not believe she is a surgical candidate at this time, as it appears treatment had been somewhat fragmented. Repeat injection would be appropriate. She hopes to avoid surgical treatment. She should undergo repeat injection and possibly repeat course of physical therapy. She may consider surgical decompression. She should definitely engage in a regular exercise program. It is noted she has other substantial issues, having returned from 4-month period of leave due to nonindustrial stress, depression and an enhancement of her fibromyalgia. It is arguable that the diffuse symptoms of fibromyalgia may be contributing to her ongoing right shoulder issues. She should be seen by an orthopedic specialist skilled in shoulder arthroscopy. The right shoulder MRI dated 7/11/2014 reveals: 1. Supraspinatus and infraspinatus tendinosis. There is localized subcortical cystic change and marrow edema within the anterior aspect of the greater tuberosity at the supraspinatus tendon insertion. 2. There is localized low signal intensity at the infraspinatus insertion on the greater tuberosity. 3. Subscapularis tendinosis and articular surface partial tearing. 4. Superior labral degenerative signal without displaced or fluid-filled tear. 5. Moderate acromioclavicular joint osteoarthritis. The 6/26/2014 initial evaluation report documents the patient is not currently working. She last worked about a week ago, and is not working because of back problem she has now. She presents for evaluation of the right shoulder. Prior treatment has been therapy, one injection which did not help, and medications. She currently describes pain in and around the shoulder that wakes her up at night at least twice a week and makes it difficult to use her arm repetitively or overhead. She also complains of neck pain. Past medical history is positive for fibromyalgia and kidney stones. She currently takes no

medications. She smokes pack of cigarettes a day and rarely drinks alcohol. Two view x-rays of the right shoulder show extensive AC joint arthritic change, no soft tissue calcifications, the humeral head centered in the glenoid, and no degenerative changes in the glenohumeral joint. Physical examination shows decreased cervical ROM in all directions with some local pain and left-sided radicular pain, essentially full ROM of the shoulder, 5/5 deltoid, biceps, IR and ER strength, 4/5 supraspinatus strength, tender over the AC joint, and positive impingement sign. According to the 7/18/2014 follow-up report, the subjective findings have not changed, and objective findings are stable. Assessment is right shoulder impingement syndrome with AC joint arthritis. Work status is deferred to PTP. Right shoulder arthroscopy is requested.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Shoulder arthroscopy/surgery:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Indications for surgery - Acromioplasty

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder; Surgery for impingement syndrome

**Decision rationale:** The guidelines also state surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, can be carried out for at least three to six months before considering surgery. In the case of this patient, the QME specifically recommended the patient undergo additional cortisone injection to the right shoulder and possibly a short course of PT and that she should engage in a regular exercise program. However, the medical records do not reflect these recommendations have been followed, a cortisone injection has not been provided recently, In addition, recent examination on 7/11/2014 does not reveal any changes. She has essentially full ROM and good functional strength. There is lacking of subjective and correlative objective clinical findings to support surgical intervention. Furthermore, the medical records do not establish failure of standard conservative care, including cortisone injection to the right shoulder. The medical records do not support that the criteria for surgical intervention have been met. In the absence of clear exhaustion of conservative measures, including recent cortisone injection with documented response, and clear evidence of functional deficits on examination, the medical necessity of surgical intervention has not been established.