

Case Number:	CM14-0148728		
Date Assigned:	09/24/2014	Date of Injury:	01/15/2013
Decision Date:	10/24/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/12/2014

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 55-year-old male coder/biller sustained an industrial injury on 1/15/13, relative to repetitive work duties. Initial conservative treatment included occupational therapy, activity modification, and medication. The 2/14/14 right shoulder MRI impression documented a type II acromion and mild osteoarthritic acromioclavicular (AC) joint changes with the adjacent supraspinatus outlet well maintained. There was no evidence of muscle atrophy and the rotator interval was clear. There was a non-displaced posterior superior labral tear partially visualized and no evidence of a high grade rotator cuff tear. The 6/13/14 treating physician report cited recurrent right shoulder pain. There was reported incomplete compliance re. the prescribed Theraband exercises. He reported approximately 4 months of relief from the previous corticosteroid injection. Physical exam documented internal rotation to T10, external rotation with arm at the side to 40 degrees, and flexion 180 degrees. There was good strength and no pain to supraspinatus, external rotation, and internal rotation testing. There were positive impingement signs. The shoulder popped when brought into external rotation. A subacromial corticosteroid injection was provided. The patient was to continue his home program. Work status was full duty. The 8/6/14 treating physician report cited continued right shoulder pain. He had decreased range of motion with pain at extremes of all motion. He was sleeping without difficulty. He was not performing Theraband exercises or taking any medications. Physical exam documented internal rotation to T10, and flexion 180 and external rotation 60 degrees. There was good strength with external rotation and supraspinatus testing. There was tenderness over the impingement area. There was no definitive AC joint tenderness. The diagnosis was impingement, resolving adhesive capsulitis, and AC joint arthritis. The patient noted improvement from the cortisone injection for 3 to 4 weeks confirming the diagnosis of impingement. Symptoms have not resolved despite extensive conservative treatment. Previous adhesive capsulitis had resolved but he continued to have pain.

The patient was frustrated by continued symptoms and wished to proceed with surgery. Right shoulder arthroscopy with subacromial decompression and possible distal clavicle resection was recommended. The 8/25/14 utilization review denied right shoulder surgery and associated requests as there was no documentation of recent exhaustive conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with Subacromial Decompression, and Possible Resection of the Distal Clavicle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Shoulder

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

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 not been met. There is no evidence of a painful arc of motion, pain at night, or abduction weakness. There is no acromioclavicular (AC) joint tenderness. Imaging documented mild osteoarthritic AC joint changes with no evidence of impingement. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. The patient last attended occupational therapy in mid-2013 and non-compliance was documented with his home exercise program. Therefore, this request is not medically necessary.

Assistant Surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeons: Role of First Assistant

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-Op Physical therapy 3x4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Post-Operative Physical Therapy.

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

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Ultrasling: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213. Decision based on Non-MTUS Citation Shoulder, Postoperative abduction pillow sling

Decision rationale: As the surgical request is not supported, this request is not medically necessary.