

<b>Case Number:</b>	CM14-0213468		
<b>Date Assigned:</b>	12/30/2014	<b>Date of Injury:</b>	04/02/2004
<b>Decision Date:</b>	02/24/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2014

### 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. 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: California

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 is a 57 year old male with a 4/2/04 injury date. In a 10/31/14 note, the patient complained of continued left shoulder pain that is primarily in the acromioclavicular (AC) joint. There was a recent AC joint injection that provided only short-term relief. Objective findings included left shoulder forward flexion to 90 degrees, external rotation to 30 degrees, and internal rotation to L3. There was pain with cross body adduction, positive impingement signs, and 4/5 cuff strength. A 7/19/14 left shoulder MRI revealed a previously repaired supraspinatus tendon, a chronic tear of the superior labrum, AC joint arthritis, mild biceps tendinosis, and evidence of previous acromioplasty but with a remaining area of lateral down-slope. Diagnostic impression: left shoulder impingement syndrome and AC joint arthritis. Treatment to date: left shoulder rotator cuff repair surgery (2012), physical therapy, medications, AC joint injection with short-term relief. A UR decision on 11/20/14 denied the request for left shoulder arthroscopic acromioplasty and distal clavicle resection (DCR), but there was no available rationale for this decision.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopic acromioplasty and DCR:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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 Chapter--Surgery for impingement syndrome, distal claviclectomy.

**Decision rationale:** The CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, the MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. The ODG supports partial claviclectomy (including Mumford procedure) with imaging evidence of significant AC joint degeneration along with physical findings (including focal tenderness at the AC joint, cross body adduction test, active compression test, and pain reproduced at the AC joint with the arm in maximal internal rotation may be the most sensitive tests), and pain relief obtained with an injection of anesthetic for diagnostic purposes. Non-surgical modalities includes at least 6 weeks of care directed towards symptom relief prior to surgery including anti-inflammatories and analgesics, local modalities such as moist heat, ice, or ultrasound. In this case, the patient's left shoulder pain generator is primarily the AC joint, which was not addressed during the 2012 surgery. There is subjective pain located at the AC joint, objective findings of tenderness over the AC joint with positive cross-body test, MRI evidence of AC joint arthritis, and short-term relief with a recent AC joint injection. In addition, there appears to be continued evidence of impingement syndrome with positive impingement signs on exam. This finding is corroborated by the recent MRI which revealed persistent down-sloping of the lateral acromion despite evidence of previous acromioplasty. The patient has had appropriate conservative treatment including physical therapy, medications, and diagnostic/therapeutic injections. At this point, it is reasonable to perform a distal clavicle excision as the primary procedure, with concurrent revision of the acromioplasty as the secondary procedure. Therefore, the request for left shoulder arthroscopic acromioplasty and DCR is medically necessary.