

Case Number:	CM14-0144882		
Date Assigned:	09/12/2014	Date of Injury:	05/27/2014
Decision Date:	10/06/2014	UR Denial Date:	08/29/2014
Priority:	Standard	Application Received:	09/08/2014

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 31-year-old male laborer sustained an industrial injury on 5/27/14. The injured worker reported an onset of right shoulder pain with repetitive work activities putting up drywall, lifting, carrying, and hammering. Initial conservative treatment included a corticosteroid injection and activity modification. The 5/24/14 right shoulder MRI impression documented tendinopathy changes of the supraspinatus and infraspinatus tendons. There was atrophy of the teres minor muscle. The radiologist questioned quadrilateral space syndrome. There were mild to moderate acromioclavicular joint degenerative changes increasing the risk for impingement. There was no evidence of acute marrow contusion or labral tear. Records indicated that the patient underwent a subacromial corticosteroid injection on 6/17/14 with 40% reduction in pain. A neurologic evaluation was requested for possible quadrilateral space syndrome. Physical therapy was recommended. The 6/19/14 electrodiagnostic study documented no electrophysiological evidence of entrapment neuropathy or radiculopathy. The 6/23/14 cervical MRI documented a C4/5 disc protrusion abutting the cord. There were disc bulges at C5/6 and C6/7 with no significant neuroforaminal narrowing or canal stenosis. The 8/14/14 treating physician report cited constant severe right shoulder pain increased with reaching and above shoulder activity. He had only temporary relief with a corticosteroid injection. Physical exam documented atrophy of the supraspinatus, infraspinatus, and teres minor. Abduction was limited to 95 degrees and internal rotation to 20 degrees. Impingement sign was positive. Abduction against resistance was 3/5. There was paresthesia over the entire right upper extremity. There was cervical paravertebral muscle tightness and bilateral trapezius spasms with restricted range of motion. The patient had not improved with conservative treatment. A pre-operative evaluation was recommended with a neurologist due to the protruded disc at C4/5 abutting the cord and possible quadrilateral space syndrome. The patient was a candidate for right shoulder arthroscopic subacromial

decompression, bursectomy, and Mumford procedure. The 8/29/14 utilization review denied the right shoulder surgery and associated requests as there was a probability of quadrilateral space syndrome and a neurologic examination was pending. The neurology consultation was certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 right shoulder arthroscopic subacromial decompression, bursectomy and Mumford procedure: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

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. The Official Disability Guidelines provide more specific indications 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 fully met. There is no detailed documentation that guideline-recommended conservative treatment had been tried for 3 to 6 months and had failed. Neurologic evaluation has been certified to evaluate the patient relative to cervical disc pathology and possible quadrilateral space syndrome. Surgical intervention is not indicated pending completion of the diagnostic work-up. Therefore, this request is not medically necessary.

Prospective request for 1 assistant surgeon: Upheld

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

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.

Prospective request for 1 medical clearance: Upheld

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

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.

Prospective request for Unknown post-op medication: Upheld

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

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.

Prospective request for 12 post-op physical therapy sessions: Upheld

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

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.