

Case Number:	CM13-0002861		
Date Assigned:	03/03/2014	Date of Injury:	05/01/2006
Decision Date:	04/22/2014	UR Denial Date:	07/11/2013
Priority:	Standard	Application Received:	07/24/2013

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 58-year-old male sustained a left shoulder injury on 5/1/06 due to repetitive work duties. He underwent left shoulder arthroscopy, SLAP lesion and rotator cuff repair on 7/18/08, and left shoulder arthroscopy with open biceps tenodesis, subacromial decompression, coracoacromial ligament release, bursectomy, and open rotator cuff repair on 8/17/11. He was also status post right biceps tendon repair on 9/1/06. The 2/4/13 AME report documented 4/6/12 left shoulder MRI findings of post-surgical changes with artifact, acromioclavicular osteoarthritis, subdeltoid and subacromial bursitis, and the radiologist's recommendation for MR arthrogram if further evaluation was clinically indicated. The AME recommended obtaining an MR arthrogram of the left shoulder to better define the pathology given the multiple injuries/surgeries. The 4/22/13 primary treating physician report indicated that the patient was still having a lot of discomfort in the left shoulder. The patient reported benefit to the last cortisone injection. Left shoulder exam findings documented abduction 120 degrees, forward flexion 140 degrees, some minor impingement signs, and slight weakness in lateral rotation. The treatment plan was limited to medications and recommended consideration of home/gym exercise. The 5/10/13 orthopedic surgeon report cited mild intermittent left shoulder pain, increased with activity. Exam findings documented 20 degrees less abduction and forward flexion in the left shoulder as compared to the right, and 45-50 degrees left internal/external rotation. Exquisite tenderness was noted over the left anterior and lateral aspect of the acromion and left AC joint tenderness. Flexion, adduction and internal rotation caused marked pain. The orthopedist requested authorization for left shoulder arthroscopy with partial resection of the distal clavicle (Mumford procedure), partial anterolateral acromioplasty with resection of the CA ligament and extensive debridement of the subacromial bursa. He also requested pre-operative testing and post-operative DME, medications, physiotherapy 2x6, acupuncture 2x6, and transportation. The 7/23/13 appeal letter

stated that the April 2012 MRI showed severe adhesions, AC joint osteoarthritis, subdeltoid subacromial bursitis, and obscured supraspinatus infraspinatus tendon. Clinical exam findings documented positive impingement testing and weak abduction against resistance. The patient had symptoms of impingement syndrome which were affecting activities of daily living and sleep, and had failed conservative treatment, including recent injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPY WITH PARTIAL RESECTION OF DISTAL CLAVICLE, PARTIAL ACROMIOPLASTY WITH RESECTION AND DEBRIDEMENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-214.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, ACROMIOPLASTY, PARTIAL CLAVICULECTOMY

Decision rationale: The California MTUS do not provide recommendations for surgery in chronic shoulder injuries. The Official Disability Guidelines recommend acromioplasty for patients with painful active arc of motion 90-130 degrees, pain at night, weak/absent abduction, rotator cuff or anterior acromial tenderness, positive impingement signs, positive diagnostic injection test, and positive MRI evidence of impingement, with failure of 3 month continuous or 6 month intermittent conservative treatment directed towards gaining full range of motion. Guidelines for partial claviclectomy require at least 6 weeks of care directed toward symptom relief and subjective, objective and clinical findings consistent with post-traumatic AC joint arthritis. Guideline criteria were not met for this surgical request. There was no documentation that recent comprehensive non-operative treatment had been tried and had failed. Recent conservative treatment had been limited to a cortisone injection, which was temporarily beneficial, and medications. Imaging evidence was documented as inadequate to fully evaluate left shoulder pathology due to artifact and post-operative changes; an MR arthrogram had been recommended but not yet accomplished. Therefore, this request for left shoulder arthroscopy with partial resection of the distal clavicle, partial acromioplasty with resection and debridement was not medically necessary.

PRE-OP CHEST X-RAY, PFT, EKG AND LABS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OF MEDICAL EVIDENCE: PRACTICE ADVISORY FOR PREANESTHESIA EVALUATION:

AN UPDATED REPORT BY THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS
TASK FORCE ON PREANESTHESIA EVALUATION

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

IFC UNIT: 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 items/services are medically necessary.

12 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.

12 ACUPUNCTURE 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.