

Case Number:	CM14-0015463		
Date Assigned:	02/28/2014	Date of Injury:	03/17/2011
Decision Date:	12/31/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/06/2014

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, has a subspecialty in Spine 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:

According to the records made available for review, this is a 53-year-old female with a 3/17/11 date of injury. At the time (8/23/13) of this request for authorization, there was documentation of subjective complaints of left shoulder pain and objective findings of tenderness over anterior as well as lateral aspect of acromion; painful flexion, adduction, and rotation over left shoulder. Imaging findings include an MRI of the left shoulder (10/24/12) revealed mild local arthritic or degenerative changes of the left acromioclavicular joint; small partial thickness tendon tear without evident tendon retraction; and focal subcentimeter, reactive, or degenerative cyst of the undersurface of the lateral left humeral head. The current diagnoses include left shoulder impingement syndrome, left subacromial bursitis, and left shoulder partial rotator cuff tear. The treatment to date includes subacromial Xylocaine/corticosteroid injection and medications. There is no documentation of additional subjective finding (pain at night) and failure of additional conservative treatment (physical therapy).

IMR ISSUES, DECISIONS AND RATIONALES

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

Partial resection of distal clavicle (Mumford procedure): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-210.

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, Subacromial Decompression and Manipulation under Anesthesia

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. Official Disability Guidelines (ODG) identifies documentation of conservative care as recommend 3 to 6 months. Noted subjective clinical findings of pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases). Objective clinical findings of weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area; positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). Imaging clinical findings should include conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of left shoulder impingement syndrome, left subacromial bursitis, and left shoulder partial rotator cuff tear. In addition, there is documentation of subjective complaints of pain with active arc motion 90 to 130 degrees. Objective findings include weak abduction and tenderness over anterior acromial area as well as failure of conservative treatment following cortisone injection and anesthetic injection (diagnostic injection test). Imaging clinical findings showing positive evidence of deficit in rotator cuff; however, there is no documentation of additional subjective finding (pain at night) and failure of additional conservative treatment (physical therapy). Therefore, based on guidelines and a review of the evidence, this request is not medically necessary.

Partial anterolateral acromioplasty with resection of coracoacromial ligament: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-210.

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, Subacromial Decompression and Manipulation Under Anesthesia

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. Official Disability Guidelines (ODG) identifies documentation of conservative care as recommend 3 to 6 months. Noted subjective clinical findings of pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases). Objective clinical findings of weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area; positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). Imaging clinical findings should include conventional x-

rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of left shoulder impingement syndrome, left subacromial bursitis, and left shoulder partial rotator cuff tear. In addition, there is documentation of subjective complaints of pain with active arc motion 90 to 130 degrees. Objective findings include weak abduction and tenderness over anterior acromial area as well as failure of conservative treatment following cortisone injection and anesthetic injection (diagnostic injection test). Imaging clinical findings showing positive evidence of deficit in rotator cuff; however, there is no documentation of additional subjective finding (pain at night) and failure of additional conservative treatment (physical therapy). Therefore, based on guidelines and a review of the evidence, this request is not medically necessary.

Extensive debridement of the subacromial bursa, possible rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-210.

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, Subacromial Decompression and Manipulation Under Anesthesia

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. Official Disability Guidelines (ODG) identifies documentation of conservative care as recommend 3 to 6 months. Noted subjective clinical findings of pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases). Objective clinical findings of weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area; positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). Imaging clinical findings should include conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of left shoulder impingement syndrome, left subacromial bursitis, and left shoulder partial rotator cuff tear. In addition, there is documentation of subjective complaints of pain with active arc motion 90 to 130 degrees. Objective findings include weak abduction and tenderness over anterior acromial area as well as failure of conservative treatment following cortisone injection and anesthetic injection (diagnostic injection test). Imaging clinical findings showing positive evidence of deficit in rotator cuff; however, there is no documentation of additional subjective finding (pain at night) and failure of additional conservative treatment (physical therapy). Therefore, based on guidelines and a review of the evidence, this request is not medically necessary.

Associated surgery services: Assistant surgeon: 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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Subacromial Decompression and Manipulation Under Anesthesia

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

Associated surgery services: Interscalene block under ultrasound: 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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Subacromial Decompression and Manipulation Under Anesthesia

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

Associated surgery services: Preoperative medical clearance consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment in Workers' Compensation (TWC), Low Back- Lumbar & Thoracic (Acute & Chronic) (Last Updated 12/27/13) Preoperative Clearance.

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, Subacromial Decompression and Manipulation Under Anesthesia

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

Associated surgery services: Preoperative medical clearance chest x-ray, electrocardiogram (EKG/ECG), pulmonary function test: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment in Workers' Compensation (TWC), Low Back- Lumbar & Thoracic (Acute & Chronic) (Last Updated 12/27/13) Preoperative Clearance for High Risk Surgeries.

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, Subacromial Decompression and Manipulation Under Anesthesia.

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

Associated surgery services: Preoperative labs including complete blood count (CBC), prothrombin time (PT), partial thromboplastin time (PTT), chem-12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment in Workers' Compensation (TWC), Low Back- Lumbar & Thoracic (Acute & Chronic) (Last Updated 12/27/13), Preoperative Lab Testing.

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, Subacromial Decompression and Manipulation Under Anesthesia

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

Left shoulder arthroscopy with arthroscopic surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-210.

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, Subacromial Decompression and Manipulation Under Anesthesia

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. Official Disability Guidelines (ODG) identifies documentation of conservative care as recommend 3 to 6 months. Noted subjective clinical findings of pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases). Objective clinical findings of weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area; positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). Imaging clinical findings should include conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of left shoulder impingement syndrome, left subacromial bursitis, and left shoulder partial rotator cuff tear. In addition, there is documentation of

subjective complaints of pain with active arc motion 90 to 130 degrees. Objective findings include weak abduction and tenderness over anterior acromial area as well as failure of conservative treatment following cortisone injection and anesthetic injection (diagnostic injection test). Imaging clinical findings showing positive evidence of deficit in rotator cuff; however, there is no documentation of additional subjective finding (pain at night) and failure of additional conservative treatment (physical therapy). Therefore, based on guidelines and a review of the evidence, this request is not medically necessary.