

Case Number:	CM14-0053372		
Date Assigned:	07/07/2014	Date of Injury:	08/20/2012
Decision Date:	08/06/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/22/2014

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:

The injured worker is a 34-year-old female who reported an injury on 08/20/2012. The mechanism of injury was not stated. Current diagnoses include left shoulder impingement; status post arthroscopic debridement on 02/11/2013; cervical sprain/strain; and elements of stress, depression, and weight gain. The injured worker was evaluated on 03/18/2014 with complaints of persistent shoulder pain. The injured worker has been previously treated with physical therapy and a cortisone injection. Physical examination on that date revealed tenderness along the rotator cuff and biceps tendon, mild tenderness along the acromioclavicular (AC) joint, positive impingement testing on the left, positive Hawkins testing on the left, positive Speed's testing on the left, and tenderness along the trapezius and shoulder girdle bilaterally. Treatment recommendations at that time included arthroscopic decompression of the left shoulder with preoperative clearance and postoperative durable medical equipment. It is noted that the injured worker underwent a magnetic resonance imaging (MRI) of the left shoulder on 11/12/2013, which indicated a previous superior labral repair, unremarkable appearance of the rotator cuff, and moderate AC joint degenerative disease.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopic Decompression: Upheld

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

Surgery Chapter, Surgery for Impingement Syndrome; Official Disability Guidelines (ODG), Indication for Surgery: Acromioplasty; Official Disability Guidelines (ODG), Shoulder Chapter, Surgery for Ruptured Biceps Tendon (at the shoulder); Official Disability Guidelines (ODG), Indications for Surgery : Ruptured Biceps Tendon Surgery; Official Disability Guidelines (ODG), Indications for Surgery: Rotator Cuff Repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. Surgery for impingement syndrome is usually arthroscopic decompression. Conservative care, including cortisone injections, can be carried out for at least 3 to 6 months prior to considering surgery. As per the documentation submitted, it is noted that the injured worker has completed a few sessions of physical therapy to date. However, the California MTUS/ACOEM Practice Guidelines recommend at least 3 to 6 months of conservative treatment. Additionally noted, the injured worker underwent a second corticosteroid injection on 03/18/2014. There is no documentation of the injured worker's response to the recent injection. Additionally, the injured worker's magnetic resonance imaging (MRI) of the left shoulder only revealed chronic degenerative changes at the acromioclavicular joint. Based on the clinical information received and the California MTUS/ACOEM Practice Guidelines, the request is not medically necessary.

Evaluation of Labrum, Biceps Tendon, and Rotator Cuff: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Surgery Chapter, Surgery for Impingement Syndrome; Official Disability Guidelines (ODG), Indication for Surgery: Acromioplasty; Official Disability Guidelines (ODG), Shoulder Chapter, Surgery for Ruptured Biceps Tendon (at the shoulder); Official Disability Guidelines (ODG), Indications for Surgery : Ruptured Biceps Tendon Surgery; Official Disability Guidelines (ODG), Indications for Surgery: Rotator Cuff Repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. Surgery for impingement syndrome is usually arthroscopic decompression. Conservative care, including cortisone injections, can be carried out for at least 3 to 6 months prior to considering surgery. As per the documentation submitted, it is noted that the injured worker has completed a few sessions of physical therapy to date. However, the California MTUS/ACOEM Practice Guidelines recommend at least 3 to 6 months of conservative treatment. Additionally noted, the injured worker underwent a second

corticosteroid injection on 03/18/2014. There is no documentation of the injured worker's response to the recent injection. Additionally, the injured worker's magnetic resonance imaging (MRI) of the left shoulder only revealed chronic degenerative changes at the acromioclavicular joint. Based on the clinical information received and the California MTUS/ACOEM Practice Guidelines, the request is not medically necessary.

Pre-op Clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Surgery Chapter, Surgery for Impingement Syndrome; Official Disability Guidelines (ODG), Indication for Surgery: Acromioplasty; Official Disability Guidelines (ODG), Shoulder Chapter, Surgery for Ruptured Biceps Tendon (at the shoulder); Official Disability Guidelines (ODG), Indications for Surgery : Ruptured Biceps Tendon Surgery; Official Disability Guidelines (ODG), Indications for Surgery: Rotator Cuff Repair.

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.

Polar Care x 21: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Surgery Chapter, Surgery for Impingement Syndrome; Official Disability Guidelines (ODG), Indication for Surgery: Acromioplasty; Official Disability Guidelines (ODG), Shoulder Chapter, Surgery for Ruptured Biceps Tendon (at the shoulder); Official Disability Guidelines (ODG), Indications for Surgery : Ruptured Biceps Tendon Surgery; Official Disability Guidelines (ODG), Indications for Surgery: Rotator Cuff Repair.

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.

Shoulder Immobilizer: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Surgery Chapter, Surgery for Impingement Syndrome; Official Disability Guidelines (ODG), Indication for Surgery: Acromioplasty; Official Disability Guidelines (ODG), Shoulder Chapter, Surgery for Ruptured Biceps Tendon (at the shoulder); Official Disability Guidelines (ODG), Indications for Surgery : Ruptured Biceps Tendon Surgery; Official Disability Guidelines (ODG), Indications for Surgery: Rotator Cuff Repair.

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.