

Case Number:	CM14-0134081		
Date Assigned:	08/27/2014	Date of Injury:	04/29/2009
Decision Date:	02/13/2015	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/21/2014

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 Sports Medicine 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 65-year-old female who reported an injury on 04/29/2009. The mechanism of injury was not provided. Her diagnoses include left shoulder impingement syndrome and left shoulder acromioclavicular joint osteoarthritis. Past treatments were noted to include physical therapy, chiropractic therapy, acupuncture, NSAIDs, and a cortisone injection. An unofficial MRI performed on 10/07/2010 was noted to reveal mild supraspinatus tendinosis, mild acromioclavicular arthrosis, mild glenohumeral joint effusion, and subcoracoid bursitis. On 07/25/2014, it was noted the injured worker had complaints of left shoulder pain and weakness which is worsened with overhead activity. On physical examination, it was noted the injured worker had decreased range of motion, measuring flexion at 120 degrees, extension was 40 degrees, abduction measured 130 degrees, adduction measured 40 degrees, and internal and external rotation measured 80 degrees. It was indicated the injured worker had tenderness to palpation over the deltoid complex, and Neer's and Hawkins' Kennedy tests were positive. Her muscle strength measured 4/5. Relevant medications were not included for review. The treatment plan was noted to include surgery and associated services. A request was received for Outpatient left shoulder diagnostic arthroscopy, SAD, distal clavicle excision, synovectomy, labral repair, RTC repair, Pre-op clearance, Post operative physical therapy (PT) times twelve (12) sessions, Post operative shoulder sling, and Post operative cold therapy unit rental times fourteen (14) days without a rationale. The Request for Authorization was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient left shoulder diagnostic arthroscopy, SAD, distal clavicle excision, synovectomy, labral repair, RTC repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

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, Diagnostic arthroscopy; Surgery for impingement syndrome; Partial claviclectomy (Mumford procedure); Surgery for SLAP lesions; Surgery for rotator cuff repair.

Decision rationale: The request for Outpatient left shoulder diagnostic arthroscopy, SAD, distal clavicle excision, synovectomy, labral repair, RTC repair is not medically necessary. According to the Official Disability Guidelines, the criteria for diagnostic arthroscopy are documentation noting pain and functional limitation despite conservative care and inconclusive imaging findings. The criteria for impingement syndrome, or subacromial decompression, are documentation noting 3 months to 6 months of previous conservative care; pain with active arc motion 90 degrees to 100 degrees, and pain at night; weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign; and imaging studies showing positive evidence of impingement. The criteria for Mumford procedure are at least 6 weeks of conservative care; pain at the AC joint or grade I or grade II AC separation; tenderness over the AC joint and/or pain relief obtained with an injection; and imaging studies indicating post-traumatic changes of the AC joint, severe degenerative joint disease of the acromioclavicular joint, complete or incomplete separation of the AC joint, and bone scan positive for AC joint separation. The Official Disability Guidelines indicate the criteria for a SLAP lesion are after 3 months of conservative care to include NSAIDs and physical therapy, over the age of 50 years old, and history and physical examinations and imaging indicate pathology. Lastly, the Official Disability Guidelines indicate that rotator cuff repair and impingement surgery are not to be in conjunction with each other. The criteria for rotator cuff repair are documentation noting conservative care for 3 months to 6 months; pain with active arc motion 90 degrees to 130 degrees and pain at night; weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign; and imaging studies indicating positive evidence of a deficit in the rotator cuff. The clinical documentation submitted for review indicated the injured worker participated in previous conservative care and had a weak abduction. It was also indicated the injured worker had positive Neer's and Hawkins' Kennedy tests and had tenderness to palpation over the deltoid complex. However, it was not indicated the injured worker had pain at night, nor was an official imaging study provided for review supporting the findings. Consequently, the request is not supported by the evidence based guidelines. As such, the request for Outpatient left shoulder diagnostic arthroscopy, SAD, distal clavicle excision, synovectomy, labral repair, RTC repair is not medically necessary.

Pre-op 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.

Post operative physical therapy (PT) times twelve (12) 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.

Post operative shoulder sling: 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.

Post operative cold therapy unit rental times fourteen (14) days: 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.