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| Case Number: | CM14-0189076 | | |
| Date Assigned: | 11/20/2014 | Date of Injury: | 07/01/2011 |
| Decision Date: | 01/08/2015 | UR Denial Date: | 10/30/2014 |
| Priority: | Standard | Application Received: | 11/12/2014 |

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 Occupational 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:

This is a 59 year old female with a 7/1/11 injury date. The mechanism of injury was described as a pulling injury to the left arm. An 8/30/13 left shoulder MRI showed chronic rotator cuff tendinopathy with a small intrasubstance tear. An 8/14/14 left shoulder x-ray series was negative. In a 9/18/14 note, the patient complained of left shoulder pain. Objective findings included left shoulder rotator cuff atrophy, a non-tender acromioclavicular joint, restricted active range of motion due to pain, positive Neer test, guarded Speed's test, and positive Obrien's test. The patient's range of motion was limited to 10 degrees internal rotation. The provider recommended right shoulder subacromial decompression. The patient has a history of surgical treatment for right shoulder impingement syndrome, but there was no evidence of prior left shoulder surgery. In addition, the left shoulder symptoms were relatively recent in onset. In an 8/21/14 note, the patient complained of persistent left shoulder pain and weakness, constant sharp pain, and disruption of sleep. Objective findings included pain-free full passive range of motion of the left shoulder. Diagnostic impression: left shoulder impingement syndrome. Treatment to date: right shoulder arthroscopy, medications. A UR decision on 10/30/14 denied the request for left shoulder diagnostic arthroscopy and subacromial decompression because the procedure was already certified on 1/14/14 and there was no documentation about whether the surgery was completed and what the outcome was.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder diagnostic arthroscopy: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Diagnostic arthroscopy

Decision rationale: CA MTUS and ODG recommend diagnostic shoulder arthroscopies with inconclusive imaging and continued pain or functional limitation despite conservative care. However, the diagnosis of impingement syndrome is fairly conclusive in this case. A diagnostic arthroscopy would not be needed for confirmation of this clinical diagnosis. In addition, it was not clear if a subacromial cortisone injection has been tried in the left shoulder. Therefore, the request for left shoulder diagnostic arthroscopy is not medically necessary.

Subacromial decompression, left shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Surgery for impingement syndrome

Decision rationale: CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. This patient has a history of surgical treatment for impingement syndrome in the contralateral shoulder, and the current symptoms in the left shoulder appear to be relatively recent in onset. However, there was no clear documentation of conservative treatment directed specifically toward the left shoulder symptoms. This would include physical therapy, anti-inflammatory medication, and subacromial cortisone injections. Therefore, the request for subacromial decompression, left shoulder, is not medically necessary.