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| Case Number: | CM14-0196291 | | |
| Date Assigned: | 12/04/2014 | Date of Injury: | 02/25/2005 |
| Decision Date: | 01/28/2015 | UR Denial Date: | 11/03/2014 |
| Priority: | Standard | Application Received: | 11/24/2014 |

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:

This is a 59 year old male with a 2/25/05 injury date. In a 10/17/14 note, the patient complained of left shoulder pain. Objective findings included left shoulder "catching and weakness." A 10/13/14 left shoulder MRI revealed mild acromioclavicular (AC) joint osteoarthritis, a partial articular surface tendon avulsion (PASTA) lesion of the supraspinatus tendon, and mild tendinopathy. In an 8/29/14 CME, the patient complained of bilateral shoulder pain. Objective findings included slightly decreased left shoulder range of motion and positive impingement signs. Diagnostic impression: left shoulder impingement syndrome, acromioclavicular (AC) joint arthrosis. Treatment to date: physical therapy, medications, injections. A UR decision on 11/3/14 denied the request for left shoulder arthroscopy, subacromial decompression (SAD), distal clavicle excision (DCE), and debridement because there was insufficient evidence of a surgical lesion or recent conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy, subacromial decompression, excision distal clavicle, and debridement, as an outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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--Surgery for impingement syndrome, Distal clavicle resection, Hospital length of stay

Decision rationale: The California 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. Official Disability Guidelines supports partial claviclectomy (including Mumford procedure) with imaging evidence of significant AC joint degeneration along with physical findings (including focal tenderness at the AC joint, cross body adduction test, active compression test, and pain reproduced at the AC joint with the arm in maximal internal rotation may be the most sensitive tests), and pain relief obtained with an injection of anesthetic for diagnostic purposes. Non-surgical modalities includes at least 6 weeks of care directed towards symptom relief prior to surgery including anti-inflammatories and analgesics, local modalities such as moist heat, ice, or ultrasound. Official Disability Guidelines supports performing shoulder arthroscopy on an outpatient basis. This patient is probably a candidate for subacromial decompression because there were objective signs of shoulder impingement and weakness, and the patient has had extensive conservative treatment. In addition, there is significant shoulder pathology on MRI that is consistent with impingement syndrome, including rotator cuff tendinosis and PASTA lesion. However, there was no documentation of tenderness over the AC joint or positive cross-body adduction test. In addition, there was no evidence of a previous cortisone injection into the AC joint. The evidence-based literature only supports a distal clavicle excision when there are clear objective signs of AC joint arthrosis on physical exam and an AC joint cortisone injection provided temporary relief of symptoms. Because the medical necessity of distal clavicle excision has not been established, the procedure as a whole cannot be considered medically necessary. Therefore, the request for left shoulder arthroscopy, subacromial decompression, excision distal clavicle, and debridement, as an outpatient is not medically necessary.