

Case Number:	CM14-0205102		
Date Assigned:	12/17/2014	Date of Injury:	10/03/2011
Decision Date:	02/10/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/08/2014

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 38-year-old female who reported injuries due to cumulative trauma on 10/03/2011. On 12/09/2014, her diagnoses included other postprocedural status, shoulder sprain, and carpal tunnel syndrome. Some of the clinical notes are handwritten and very difficult to read. Her complaints included right shoulder pain. She had decreased range of motion. An MRI of the upper extremity on 10/10/2014 revealed a type 2 acromion with degenerative change in the acromioclavicular joint and mild narrowing of the subacromial space. It was noted that these may predispose to impingement syndrome, and clinical correlation was suggested. There was no evidence of rotator cuff or labral tear. On 08/22/2014, it was noted that she had a right carpal tunnel release on 01/24/2014. Her complaints included pain over the superior aspect of the right shoulder, which was increased with motion and use. She noted that the pain woke her up at night. She was not receiving any physical therapy. She was taking ibuprofen on an as needed basis. Upon examination, the alignment of the right shoulder was normal without muscle atrophy, deformity, or sag. There was minimal tenderness to palpation over the anterior and superior aspects of the shoulder. There was full range of motion, except for a 10 degree loss of flexion with mild pain. She had a positive Neer sign with a mildly tender supraspinatus test. There was no tenderness, swelling, deformity, or atrophy of the right upper arm. She declined nonsteroidal anti-inflammatory medication, physical therapy, and steroid injections to the right shoulder and stated that she had been treated with these in the past with minimal to fair temporary relief. Surgery was discussed, and she was willing to proceed with the surgery. There was no Request for Authorization included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arch decompression partial distal clavicle extension: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-1. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter; (Iowa Orthop J. 2005; 25: 149-156 (<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1888780>) and Wheelless Text of Orthopaedics Online

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The request for arch decompression partial distal clavicle extension is not medically necessary. The California ACOEM Guidelines note that referral for surgical consultation may be indicated for patients who have red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.); activity limitation for more than 4 months, plus existence of a surgical lesion; failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; and clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. Surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care, including cortisone injections, can be carried out for at least 3 to 6 months before considering surgery. It was noted that this injured worker declined nonsteroidal anti-inflammatory medications, physical therapy, and steroid injections to the right shoulder, which are recommended in the guidelines. Additionally, it is unclear what a distal clavicle extension is. The guideline criteria have not been met. Therefore, this request for arch decompression partial distal clavicle extension is not medically necessary.