

Case Number:	CM15-0131488		
Date Assigned:	07/17/2015	Date of Injury:	04/19/2012
Decision Date:	08/18/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	07/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Minnesota, Florida
 Certification(s)/Specialty: Orthopedic Surgery

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 33-year-old male injured the low back and left shoulder on April 19, 2012. The documentation dated April 16, 2015 indicates left shoulder pain associated with swelling, clicking, locking, tingling, popping, grinding, stiffness, weakness and numbness. Physical examination revealed 90° of abduction with tenderness. There was a crepitus noted with internal and external rotation associated with pain. There was mild-to-moderate acromioclavicular joint swelling with moderate tenderness. The diagnosis was impingement, left shoulder. The plan was a repeat MRI scan. He was also placed on Vicodin and Naprosyn. A subsequent MRI report pertaining to the left shoulder dated 5/6/2015 revealed the following impression: 1. Grade 1 strain of the anterior belly of the deltoid muscle. 2. No rotator cuff tear. 3. Labral tearing, at least posteroinferiorly, superiorly, and anterosuperiorly. In this decreased sensitivity examination correlation with MR arthrogram could be considered. 4. Partially visualized focal area of fat signal in the infraspinatus muscle an MR arthrogram is recommended for confirmation. This request pertains to arthroscopic debridement, synovectomy and subacromial decompression and Mumford procedure for the left shoulder. The request was noncertified by utilization review for lack of documentation of conservative treatment. There was no recent documented exercise rehabilitation program with corticosteroid injections as necessitated by California MTUS guidelines for 3-6 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic, debridement, synovectomy, SAD, mumford: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211, 213. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Partial claviclectomy.

Decision rationale: California MTUS guidelines indicate surgery for impingement syndrome is usually arthroscopic decompression. The 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 3-6 months before considering surgery. 2 or 3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome or small tears is recommended. In this case, the documentation provided does not indicate any recent comprehensive exercise rehabilitation program with corticosteroid injections and physical therapy. As such arthroscopy with subacromial decompression is not supported. Furthermore, the MRI scan did not show evidence of severe acromioclavicular arthritis necessitated by ODG guidelines for a Mumford procedure. A trial/failure of conservative treatment for acromioclavicular pain is also not documented. As such, the request for a Mumford procedure is also not supported and the medical necessity of the requests for arthroscopic subacromial decompression and Mumford procedure has not been substantiated. The request is not medically necessary.