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| Case Number: | CM15-0141659 | | |
| Date Assigned: | 07/31/2015 | Date of Injury: | 05/20/2014 |
| Decision Date: | 08/28/2015 | UR Denial Date: | 07/10/2015 |
| Priority: | Standard | Application Received: | 07/21/2015 |

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: California, Oregon, Washington
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:

The injured worker is a 53 year old male, who sustained an industrial injury on 5-20-14. The injured worker has complaints of left elbow, left shoulder and cervical spine pain. The documentation noted on examination that there is spasm and tenderness observed over the paravertebral muscles of the cervical spine with decreased range of motion on flexion and extension. The diagnoses have included shoulder impingement and shoulder tendinitis and bursitis. Treatment to date has included magnetic resonance imaging (MRI) of the cervical spine from 12-15-14 revealed multilevel disc protrusion posteriorly and uncovertebral osteophyte formation, left greater than right with bilateral exiting nerve root compromise; physical therapy; transcutaneous electrical nerve stimulation unit; heat and ice. The request was for 1 left shoulder arthroscopy with sybacromial decompression and mumford (distal clavical resection).

IMR ISSUES, DECISIONS AND RATIONALES

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

1 left shoulder arthroscopy with sybacromial decompression and mumford (distal clavical resection): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Partial Claviclectomy.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 7/9/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case, the exam note from 7/19/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore, the determination is for non-certification. Based upon the CA MTUS Shoulder Chapter. Pgs 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviclectomy, states surgery is indicated for post-traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case, the exam note from 7/9/15 and the imaging findings from 12/16/2014 do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore, the request is not medically necessary.