

Case Number:	CM15-0147713		
Date Assigned:	08/10/2015	Date of Injury:	03/10/2011
Decision Date:	09/25/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/29/2015

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 injured worker is a 66 year old male who reported an industrial injury on 3-10-2011. His diagnoses, and or impression, were noted to include: left shoulder "SLAP" tear and acromioclavicular joint osteoarthritis. No current imaging studies of the left shoulder were noted. His treatments were noted to include: a qualified medical evaluation (12-15-14); consultation; diagnostic studies; medication management; and modified work duties. The progress notes of 6-16-2015 reported a follow-up visit for unchanged and ongoing, moderate left shoulder pain that radiated to the left side of the neck, arm, elbow and fingers, left hip, and right ankle, and was aggravated by activities. Objective findings were noted to include: tenderness over the acromioclavicular joint with positive Neer and Hawkins tests and restricted range-of- motion due to pain. The physician's requests for treatments were noted to include left shoulder arthroscopy and decompression with left shoulder sling, with a post-operative cold therapy unit and physical therapy.

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: 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): s 211, 213.

Decision rationale: Per QME of June 16, 2015, the injured worker was complaining of left shoulder pain, headache, jaw pain, neck pain, back pain, and left knee pain status post surgery. He also complained of left arm pain, locking and grinding of jaw. He had attended 12 sessions of physical therapy/chiropractic treatment but the notes do not specify how many treatments for the shoulder or the duration of the physical therapy. On examination there was tenderness to palpation noted over the acromioclavicular joint with Neer and Hawkins testing positive. Range of motion was restricted due to pain. The notes also do not document any corticosteroid injections into the shoulder. The nature of the previous surgery on the left shoulder and the outcome of that surgery have not been documented. An MRI scan of the left shoulder revealed moderate supraspinatus tendinosis with no rotator cuff tear. Changes of remote anchor placement in the anterior glenoid with intact shoulder capsule and labrum detected. There is Arthrosis of the acromioclavicular joint with no compression on the supraspinatus complex, otherwise, unremarkable for age. The California MTUS guidelines indicate surgery for impingement syndrome is subacromial decompression. 3-6 months of an exercise rehabilitation program with physical therapy and 2-3 corticosteroid injections with trial/failure should be documented prior to surgical intervention. The documentation submitted does not indicate a recent comprehensive nonoperative treatment protocol with trial/failure necessitated by guidelines. As such, the medical necessity of the request for arthroscopy with subacromial decompression of the left shoulder has not been substantiated. The request is not medically necessary.

Associated surgical service: left shoulder sling: 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 Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 211 and 213.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post op physical therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 211 and 213.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical service: Cold therapy unit: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 211 and 213.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.