

Case Number:	CM15-0185895		
Date Assigned:	09/28/2015	Date of Injury:	04/03/2012
Decision Date:	12/02/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/21/2015

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: Illinois, California, Texas
 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 41-year-old female who sustained an industrial injury on 4/3/12. Injury was reported relative to cumulative trauma as a cashier. She underwent right carpal tunnel release on 9/2/14, left carpal tunnel release in 12/2/14, and a right cubital tunnel release, date unknown. The 7/16/15 physical therapy progress report documented some progress in strength and range of motion with 12 visits of physical therapy. Left shoulder range of motion had increased in flexion from 140 to 160, abduction from 98 to 130, external rotation from 50 to 70, and internal rotation from 65 to 75 degrees. Left shoulder strength on 6/1/15 was noted as 3/5 flexion, 3/5 abduction, 3/5 external rotation, and 3/5 internal rotation. On 7/16/15, strength had improved to 4/5 in flexion, abduction, external rotation, and internal rotation. She was tolerating daily activities better. She had continued difficulty in overhead lifting and prolonged upper extremity use. She was instructed in a progressive left upper extremity strength and stretching exercise program with emphasis on rotator cuff and scapular strengthening. She was independent in her home exercise program. The 8/4/15 treating physician cited refractory left shoulder pain. Shoulder exam documented positive Neer's, and Hawkin's tests. Range of motion was documented as flexion 145, abduction 120, external rotation 70, and internal rotation 50 degrees. The diagnosis included left shoulder subacromial impingement syndrome with possible rotator cuff tear. The injured worker had undergone 3 left shoulder injections, which gave her temporary relief. Authorization was requested for left shoulder arthroscopy with subacromial decompression, pre-operative medical clearance, pre-operative physical, pre-operative EKG, and pre-operative labs. The 8/31/15 utilization review non-certified the left shoulder arthroscopy with

subacromial decompression and associated pre-operative requests as there was no clinical evidence of a painful arc of motion, pain at night, weak or absent abduction, or rotator cuff or anterior acromial tenderness, and no imaging studies to corroborate impingement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopy, Left Shoulder, with subacromial decompression: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - Surgery for impingement syndrome; Acromioplasty.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for impingement syndrome; Surgery for rotator cuff tear.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines provide indications for impingement syndrome and partial thickness rotator cuff repairs that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement or rotator cuff deficiency. Guideline criteria have not been met. This injured worker presents with continued left shoulder pain and difficulty in overhead lifting and prolonged upper extremity use. Clinical exam findings are consistent with impingement syndrome. She had temporary relief with left shoulder subacromial injections. However, there are no radiographic or imaging findings documented or reports available in the submitted records to corroborate impingement or rotator cuff pathology. The injured worker has demonstrated good improvement in range of motion and strength with recent physical therapy, and improved activities of daily living function. There is no evidence that she has failed physical therapy. Therefore, this request is not medically necessary at this time.

Preoperative Medical Clearance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Preoperative Physical: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Preoperative EKG (electrocardiogram): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Preoperative Labs: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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