

Case Number:	CM15-0190460		
Date Assigned:	10/02/2015	Date of Injury:	01/31/2011
Decision Date:	11/10/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/28/2015

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 male who sustained an industrial injury on 1/31/11. The mechanism of injury was not documented. The 2/23/15 through 7/29/15 treating physician reports indicated that the patient was not attending any therapy or other modes of treatment. Medications were sufficient on a partial basis for his shoulder, elbow, and low back pain. The diagnosis included intractable lumbar pain, lumbar radiculopathy, left shoulder tendinosis, and left elbow tendinosis. He was reportedly waiting to be authorized for shoulder surgery. The 8/17/15 treating physician report cited continued shoulder and elbow pain. Left shoulder exam documented flexion and abduction less than 120 degrees with positive impingement and Hawkin's signs. There was lateral epicondyle tenderness, exacerbated by resisted wrist extension. The injured worker reportedly had significant pain with loss of function despite conservative management with medical and physical therapy. Shoulder MRI showed a partial tear of the rotator cuff with severe tendonitis. The injured worker did not want a corticosteroid injection. Authorization was requested for left shoulder arthroscopy decompression. The 9/1/14 utilization review non-certified the request for left shoulder arthroscopy decompression as there was no documentation of subjective findings relative to painful arc of motion and pain at night, and no documentation of an MRI report.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy Decompression: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter.

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 repair.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery and rotator cuff surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific 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. Guidelines typically require imaging clinical findings with conventional x-rays, AP, and true lateral or axillary view, and MRI, ultrasound, or arthrogram showing positive evidence of impingement. Guideline criteria have not been met. This injured worker presents with chronic and function-limiting left shoulder pain. Clinical exam findings evidenced limited range of motion with positive impingement signs, there was no current documentation relative to strength, tenderness, nighttime pain, or painful arc of motion. There was reported evidence of a partial tear of the rotator cuff with severe tendonitis, but there was no MRI or x-ray report available in the submitted medical records to demonstrate rotator cuff pathology or impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.