

Case Number:	CM15-0199680		
Date Assigned:	10/14/2015	Date of Injury:	09/04/2014
Decision Date:	11/25/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/12/2015

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 55-year-old male who sustained an industrial injury on 9/4/14. Injury occurred when he stepped off a track loader and his right ankle turned in causing him to fall. He landed on his outstretched left arm, fracturing his left wrist, injuring his left shoulder, and hitting his head resulting in a loss of consciousness. The 11/6/14 left shoulder MRI impression documented degenerative arthritis of the left acromioclavicular (AC) joint and lateral down-sloping of the Type 1 acromion with normal subacromial space. There was degenerative arthritis of the glenohumeral joint. Conservative treatment for the left shoulder had included physical therapy, medications, and activity modification. The 9/21/15 treating physician report cited left shoulder pain with aching pain to the left hand into the 4th and 5th fingers with numbness and tingling. He reported left wrist popping, throbbing left hand pain at night, limited left shoulder range of motion, and the left hand constantly fell asleep at night. Left shoulder exam documented moderate tenderness over the anterolateral border of the acromion, anterior aspect of the left clavicle, and supraspinatus. There was trace effusion and global 4/5 left shoulder weakness. Left shoulder range of motion documented flexion 120, abduction 115, extension 30, adduction 20, and inter/external rotation 70 degrees. Impingement and Apley's scratch tests were positive. The diagnosis was rotator cuff syndrome. Authorization was requested for left shoulder arthroscopy and debridement and post-op physical therapy 3x4 for the left shoulder. The 9/24/15 utilization review non-certified the request for left shoulder arthroscopy and debridement and associated post-op physical therapy as there was no detailed evidence of 3 to 6 months of physical therapy or performance of a home exercise program, as well as consideration for steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopy and debridement of the left shoulder: Upheld

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

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 rotator cuff repair; Surgery for impingement syndrome.

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. Guideline criteria have not been fully met. This injured worker presents with persistent left shoulder pain. There are clinical exam findings of limited range of motion, anterior tenderness, generalized weakness, and positive impingement tests. There is imaging evidence of AC joint arthritis and plausible impingement. There is detailed evidence of physical therapy including to the left shoulder, medications, and activity modification. However, there is no documentation of a positive diagnostic/therapeutic cortisone injection for impingement. Therefore, this request is not medically necessary.

Post-op physical therapy 3 times 4 for the left shoulder: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.