

Case Number:	CM15-0219626		
Date Assigned:	11/12/2015	Date of Injury:	08/06/2014
Decision Date:	12/24/2015	UR Denial Date:	10/29/2015
Priority:	Standard	Application Received:	11/09/2015

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:

The injured worker is a 26-year-old female who sustained an industrial injury on 8/6/14. Injury occurred when she was lifting a heavy bucket from a table with now of low back and right shoulder pain. Conservative treatment included physical therapy, acupuncture, chiropractic, activity modification, and medications. The 3/3/15 orthopedic consultation report cited current symptoms of low back, neck, and right shoulder and wrist pain. Functional difficulty was documented in lifting, grasping, and carrying. Physical exam documented subacromial and biceps tenderness, and positive improvement in abduction and internal/external rotation. Right shoulder range of motion testing documented forward flexion 110, abduction 120, internal rotation 50, external rotation 40, extension 30, and adduction 20 degrees. Left shoulder range of motion was full. Upper extremity strength was reported intact. Deep tendon reflexes were symmetrical. X-rays of the right shoulder were reported normal. MRI was recommended. The 5/14/15 right shoulder MRI impression documented subchondral cyst formation within the humeral head and supraspinatus, infraspinatus, and subscapularis tendinosis. The acromioclavicular (AC) joint appeared normal and acromion was Type 1. Occult tears of the rotator cuff were not excluded by conventional sequences. The 8/25/15 orthopedic surgery report documented right shoulder symptoms had improved following injection to allow return to modified work. Range of motion was normal. Re-evaluation was planned for one month. The 9/29/15 orthopedic surgery report cited intermittent moderate right shoulder pain. A right shoulder injury had helped the pain for a few weeks. Physical exam documented right shoulder tenderness with positive impingement. The treatment plan recommended right shoulder

decompression surgery as indicated. The injured worker was working. Authorization was requested for right shoulder arthroscopy, pre-operative consultation, and 12 sessions of post-operative physical therapy. The 10/29/15 utilization review non-certified the right shoulder surgery and associated surgical requests as the MRI did not reveal any specific tears or ligamentous disruption, and there was no detailed documentation as to the outcome of conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy: 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 impingement syndrome.

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 more specific indications for impingement syndrome 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 intermittent moderate right shoulder pain with movement. She has been able to return to modified duty. Clinical exam findings evidenced tenderness and a positive impingement sign. There is no current documented range of motion or strength deficit. Imaging documented rotator cuff tendinosis with no evidence of impingement. Radiographs were reported normal. There is evidence of reasonable long-term conservative treatment for this injury but the specific response to shoulder treatment, beyond injection, was not provided. In the absence of clear imaging evidence of a surgical lesion and current comprehensive shoulder examination, the medical necessity of surgical intervention is not established. Therefore, this request is not medically necessary.

Preoperative consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd edition 2004, Chapter 7: Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post operative physical therapy, 3 times weekly for 4 weeks, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.