

Case Number:	CM15-0033363		
Date Assigned:	02/26/2015	Date of Injury:	03/07/2012
Decision Date:	04/09/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/23/2015

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 41-year-old female who sustained an industrial injury on 3/7/12. Injury occurred when she pulled a couch to vacuum behind it, and felt pain in her left arm. Past medical history was positive for diabetes. The 8/28/12 left shoulder MRI impression documented mild to moderate rotator cuff tendinosis with mild to moderate acromioclavicular (AC) joint degenerative change and small focal partial undersurface supraspinatus tendon tear. The 10/19/12 cervical MRI documented degenerative disc disease with disc protrusions and retrolisthesis at C3/4 and C4/5 without canal or neuroforaminal stenosis. The progress reports from 3/23/13 to 4/2/14 documented conservative treatment to include Norco, Elavil, and Prilosec, topical cream, chiropractic treatment to the cervical spine, hand therapy to the left hand, and one visit of acupuncture. The 4/24/14 treating physician report cited increasing left shoulder pain over the past month, and left wrist pain worse with repetitive movements. Left shoulder exam documented active and passive range of motion as flexion 110, extension 60, abduction 110, external rotation 90, and internal rotation 70 degrees. There was tenderness to palpation over the AC joint and along the trapezius. There was no instability. Neer's, Hawkin's, Speed's, and O'Brien's tests were positive. Upper extremity strength, sensation and reflexes were within normal limits. The diagnosis included left shoulder bursitis, impingement, and rotator cuff tendinitis, left medial epicondylitis, left wrist tendinitis, and cervical radiculopathy. The treatment plan noted that left shoulder surgery had been requested, and recommended continued work restrictions and medications. The 1/3/15 treating physician report cited grade 8/10 left shoulder pain and grade 5/10 neck and left upper extremity symptoms affecting activities of daily

living. The injured worker continued to complain of reactive depression with no suicidal ideation. Left shoulder exam documented limited range of motion and left deltoid muscle atrophy. The treatment plan recommended left shoulder subacromial decompression. On 2/4/15, utilization review non-certified requests for left shoulder arthroscopic subacromial decompression and Psychological evaluation to address reactive depression. The rationale for non-certification of the left shoulder surgery cited no documentation of a subacromial corticosteroid injection and limited conservative treatment. The rationale for non-certification of psychological evaluation cited no documentation relative to the length of the depression symptoms. The Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic 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): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement 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 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, and positive impingement sign with a positive diagnostic injection test. Conventional x-rays, AP, and true lateral or axillary view, AND MRI, ultrasound, or arthrogram showing positive evidence of impingement are required. Guideline criteria have not been met. The injured worker presents with left shoulder pain limiting activities of daily living. Imaging evidence documented mild to moderate AC joint osteoarthritis with a partial supraspinatus tear. Clinical exam findings in April 2014 documented positive impingement testing. There is no evidence of a positive diagnostic injection test. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the left shoulder and failure has not been submitted. Therefore, this request is not medically necessary.

Psychological evaluation to address reactive depression: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluation Page(s): 100-101.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Psychological evaluations Page(s): 100-101.

Decision rationale: The California MTUS guidelines state that psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. Guideline criteria have been met. This patient presents with chronic neck and left upper extremity pain, long-term opioid use, and reported reactive depression. Given these clinical indications, this request is medically necessary.