

<b>Case Number:</b>	CM15-0055034		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	10/03/2014
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 45-year-old female who reported injury on 10/03/2014. There was a Request for Authorization submitted for review dated 03/03/2015. The mechanism of injury was not provided. The documentation of 02/17/2015 revealed the injured worker had a subacromial injection of the left shoulder that gave temporary relief. The injured worker was noted to be beginning physical therapy. The injured worker had pain and discomfort in the left shoulder with some weakness in the left arm. The physical examination revealed full range of motion. There was no atrophy of the upper arm. There was no periscapular muscle wasting or winging. The strength was 5/5. The distal sensation was within normal limits. The biceps and triceps reflex were within normal limits. There was no tenderness at the acromioclavicular joint, sternoclavicular joint, or periscapular bursa. There was no tenderness at the subacromial bursa or greater tuberosity. There was a positive Neer's and positive Hawkins testing of the left shoulder. The documentation indicated the injured worker had an MRI and per the physician the documentation indicated the injured worker had a super and subscapular tendinitis with a type 3 down sloping acromion morphology with impingement of the rotator cuff. The diagnosis included external impingement of the left shoulder with partial bursal sited rotator cuff fraying, AC joint degeneration, status post work related injury, and treatment with subacromial injection. The treatment plan included an arthroscopic surgical intervention. The MRI dated 01/11/2015 revealed the injured worker had mild supraspinatus and subscapularis tendinosis with no evidence of rotator cuff tear. There was a type 3 acromion with mild lateral down sloping of the acromion.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder diagnostic/operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa as indicated, possible distal clavicle resection:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210 and 211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210 and 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Diagnostic Arthroscopy.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have a failure to increase range of motion and strength of musculature in the shoulder after exercise programs and who have clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. For injured workers with a partial thickness or small full thickness tear, impingement surgery is reserved for cases failing conservative care therapy for 3 months and who have imaging evidence of rotator cuff deficit. For surgery for impingement syndrome, there should be documentation of conservative care including cortisone injections for 3 to 6 months before considering surgery. The referenced guidelines do not address Diagnostic Arthroscopy. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that a Diagnostic arthroscopy is limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Additionally, if a rotator cuff tear is shown to be present following a diagnostic arthroscopy, the guidelines for a full or partial thickness tear would be followed. The clinical documentation submitted for review indicated the injured worker had a positive Hawkins and Neer's impingement test. The injured worker was noted to have minimal pain relief from a corticosteroid injection. The MRI revealed positive findings of a type 3 acromion, which would not be an inconclusive finding. There was a lack of documentation indicating a failure of conservative care. It was noted the injured worker was just starting conservative care. Given the above, the request for left shoulder diagnostic/operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa as indicated, possible distal clavicle resection is not medically necessary.

**Associated surgical services: medical clearance to include; labs (CBC, CMP, PT/PTT, HEP/HIV panel, UA), EKG, and chest x-ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter - Lumber & Thoracic (Acute & Chronic).

**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.

**Post-operative physical therapy (12 sessions):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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.

**Post-operative sling:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

**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.