

Case Number:	CM15-0057207		
Date Assigned:	04/02/2015	Date of Injury:	07/06/2012
Decision Date:	05/15/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/25/2015

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 59-year-old who reported an injury 07/06/2012. The mechanism of injury was not provided. He was diagnosed with shoulder bursitis, bicipital tendinitis, and DGD of the shoulder area. His past treatments were noted to include medications, physical therapy and surgery. His diagnostic studies included an official MRI of the right shoulder performed on 02/03/2015. Which was noted to reveal no definitive full thickness tear of the rotator cuff is seen; however, there is extensive tendinopathy of the supraspinatus with evidence of calcific tendinitis. Follow-up arthrogram study may be helpful to further access, as clinically indicated; acromioclavicular joint arthropathy is seen with a type 2 acromion; glenohumeral joint synovitis. Surgical history was noted to include status post right shoulder FAD, DCE partial thickness rotator cuff repair on 10/11/2012. On 02/11/2015, the injured worker reported increased pain over the past few weeks. He indicated his pain was aggravated with work and abduction/overhead movements. He indicated he is not taking any medication other than Advil as needed. Upon physical examination of the right shoulder, he was noted to have full active range of motion with terminal forward flexion and abduction pain with AC joint area discomfort at end of distal clavicle. The injured worker had a positive Neers and Hawkins sign. There was positive cross arm abduction. No obvious deformity, erythema, ecchymosis or swelling was present. His current medications included Advil as needed. The treatment plan included lab study results, review of injured worker's old records, education, Request For Authorization for right shoulder arthroscopy and interposition graft of residual AC joint with post cold therapy device, abduction sling, post PT for 16 visits, and return to clinic for preop evaluation once

approved. A request was submitted for Right shoulder arthroscopy with interposition graft of AC joint; however, the rationale was provided. On 03/13/2015 the requesting provider provided an appeal letter. A treating physician indicated the injured worker underwent a right shoulder arthroscopy with partial rotator cuff tear repair, an open distal clavicle excision on 10/11/2012. The injured worker received postoperative physical therapy and home exercises and succeeded in his early recover for the surgery. However, as time went on the injured worker developed clicking and painful popping/crepitus at the site of the prior distal clavicle excision where the residual distal clavicle opposes the acromion. The treating physician indicated that a provided local steroid injections, physical therapy, referrals, occupational modifications, acupuncture referrals. Despite all of the treatments the injured worker continued to be symptomatic and therefore, a request for right shoulder arthroscopy and interposition graft of the residual AC joint has been requested. The requesting provider indicated at this point no viable options, outside of surgery, that will provide durable benefit for the injured worker is noted. A Request for Authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with interposition graft of AC joint: 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): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for AC joint separation.

Decision rationale: The California MTUS/ACOEM Guidelines state patients with a AC joint separation would be treated conservatively. More specifically, the Official Disability Guidelines state criteria for surgical treatment of acromioclavicular disc location should include conservative treatment for at least 3 months, pain with marked functional difficulty, objective clinical findings marked deformity, and conventional x-rays showing grade 3 plus separation. The clinical documentation submitted for review does provide evidence of conservative care for at least 3 months and pain with mark functional difficulty. However, there is no evidence of objective findings such as mark deformity and imaging clinical findings of conventional x-ray showing grade 3 plus separation. In the absence of this documentation, the request would not be supported. As such, the request for right shoulder arthroscopy with interposition graft of ac joint is not medically necessary.

Post-op physical therapy x 16: 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 right shoulder abduction sling: 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), <http://www.odg-twc.com/odgtwc/shoulder.htm#Protocol>.

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.

Associated surgical service: Cold therapy device: 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), Continuous-flow cryotherapy.

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.

Pre-op evaluation: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.