

<b>Case Number:</b>	CM15-0058087		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	10/08/2013
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	03/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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 52-year-old female who reported an injury on 10/08/2013. The mechanism of injury was the injured worker lifted a part weighing approximately 25 pounds and extended her arms to position the part on precision blocks and the left shoulder popped, following by a burning pain going down the shoulder to the arm. Prior therapies included a corticosteroid injection (which helped temporarily) and physical therapy. The injured worker underwent an MRI of the left shoulder on 02/12/2014 that revealed moderate tendinosis involving the supraspinatus and subscapularis tendons and there was moderate fluid and subacromial and subdeltoid bursitis. There was a type 2 acromion with no evidence of lateral acromial spurring. There were moderate hypertrophic changes the acromioclavicular joint. The documentation of 02/23/2015 revealed the injured worker had decreased range of motion of the bilateral shoulders. The injured worker had acromioclavicular joint tenderness on the left. The anterior joint capsule was palpated and was tender on the left. Strength was 4/5 in flexion. The injured worker had pain to the anterior shoulder capsule with cross chest maneuver on the left. The injured worker had a positive Hawkins impingement maneuver on the left with a negative Neer's. The treatment plan included diagnostic arthroscopy with subacromial decompression, repair of the rotator cuff, and excision of the distal clavicle; DME; physical therapy; and a cold compression unit for 7 days. The documentation of 03/23/2015 revealed the injured worker had ongoing discomfort in the bilateral shoulders. The injured worker had tenderness to palpation over the anterior shoulder; tenderness to palpation over the trapezius and lateral deltoid; and passive range of motion of 100 degrees of flexion, 90 degrees of abduction, and internal and

external rotation to 60 degrees. The injured worker had weakness in forward flexion and abduction at 4/5. Special maneuvers were deferred due to limited range of motion. The diagnoses included adhesive capsulitis (left shoulder), acromioclavicular joint arthrosis (left shoulder) by plain film radiographs, and impingement morphology (left shoulder) by plain film radiographs. The treatment plan included a reconsideration for a left shoulder arthroscopy with manipulation under anesthesia. There was a request for authorization submitted for review dated 03/05/2015.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Repair Rotator Cuff and Excision Distal Clavicle: 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): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Partial Claviculectomy.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates 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. They do not however address Mumford resection. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that for a partial claviculectomy, there should be documentation of at least 6 weeks of care directed toward symptomatic care, plus pain at the AC joint and aggravation of pain with shoulder motion or carrying weight, plus there should be tenderness over the AC joint and pain relief with an injection of anesthetic for diagnostic therapeutic trial plus there should be conventional films showing post-traumatic changes of the AC joint. The clinical documentation submitted for review indicated the injured worker had undergone physical therapy. However, there was a lack of documentation of either a partial thickness or a full thickness tear. There was a lack of documentation of the duration of conservative care. There was a lack of documentation indicating exceptional factors to warrant nonadherence to guideline recommendations. Additionally, the request as submitted failed to indicate the laterality for the request. Given the above, the request for repair rotator cuff and excision distal clavicle is not medically necessary.

#### **Left Shoulder Diagnostic Arthroscopy, Subacromial Decompression: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder (updated 02/27/15).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 210-211.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates 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 clinical documentation submitted for review indicated the injured worker had undergone physical therapy. However, there was a lack of documentation of either a partial thickness or a full thickness tear. There was a lack of documentation of the duration of conservative care. There was a lack of documentation indicating exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for left shoulder diagnostic arthroscopy, subacromial decompression is not medically necessary.

**Surgical Assistant:** 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.

**Pre-Operative CBC:** 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.

**Associated Surgical Service: EKG:** 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.

**Associated Surgical Service: Comprehensive Metabolic Panel (CMP):** 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.