

<b>Case Number:</b>	CM15-0059119		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	12/24/2012
<b>Decision Date:</b>	05/26/2015	<b>UR Denial Date:</b>	03/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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 male who reported an injury on 12/24/2012. The mechanism of injury was a slip and fall. His diagnoses included left shoulder rotator cuff tendonitis with type 2 acromion morphology and partial tear of the cuff; left elbow severe lateral epicondylitis; medial epicondylitis left elbow; status post ORIF of bones forearm fracture; partial rotator cuff tear. His past treatments have included surgery and postoperative physical therapy. Diagnostic studies have included an MRI of the elbow without contrast performed on 01/02/2015. An electromyogram performed on 10/16/2014. His surgical history has included open reduction and internal fixation of both bones of the forearm. The injured worker was seen on 03/04/2015 for consultation and evaluation of his left shoulder and left elbow. On physical exam, the left shoulder range of motion was measured in forward flexion at 90 degrees, abduction at 105 degrees, external rotation at 90 degrees, and internal rotation to T8. There was tenderness at the acromioclavicular joint, a negative anterior AC joint stress test, a negative posterior AC joint stress test. There was no tenderness at the sternoclavicular joint nor subluxation or instability of the sternoclavicular joint. The scapular had no tenderness at the periscapular bursa, scapulothoracic crepitus, and a normal scapulothoracic motion. The rotator cuff had tenderness noted at the subacromial bursa. There was a positive provocation near impingement sign, and a positive provocative Hawkins impingement sign. There was no tenderness noted at the bicipital groove, negative Speed's test, and negative Yergason's sign, and positive proactive O'Brien's test. There was no evidence of instability on manual manipulation of the shoulder joint. His medications were not included. The treatment plan included consideration of diagnostic

operative arthroscopic surgery of the left shoulder. The rationale for the request was not included. The Request for Authorization form was signed and dated 03/13/2015 in the medical record.

### **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: 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder, Surgery for impingement syndrome.

**Decision rationale:** The ACOEM guidelines indicate that surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or for those who have neuro activity limitations. Conservative care, including cortisone injections, for at least 3 to 6 months are recommended before considering surgery. The Official Disability Guidelines state the criteria for acromioplasty includes conservative care of at least 3 to 6 months; Pain with active arc motion and pain at night; Weak or absent abduction and tenderness over rotator cuff or anterior acromial area, and positive impingement sign with temporary relief of pain with an anesthetic injection. Imaging findings that include MRI shows positive evidence of impingement. As there is a lack of documentation regarding conservative care over the last 3 to 6 months to include physical therapy, medications, home exercise program; documented pain with active arc motion with pain at night, and temporary relief of pain with anesthetic injection, the request for left shoulder diagnostic/operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa is not medically necessary.

#### **Possible distal clavicle resection: 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome.

**Decision rationale:** The Official Disability Guidelines state that operative treatment including isolated distal clavicle resection or subacromial decompression, may be considered in the treatment of patients whose condition does not improve after 6 months of conservative therapy or of patients younger than 60 years with debilitating symptoms that impair function. There is a lack of documentation regarding 6 months of conservative therapy and as the decision for left

shoulder diagnostic/operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa was not medically necessary, this request is also not medically necessary.

**Associated surgical service: Post-op PT x 12:** 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: Medical clearance [CBC, CMP, PT/PIT, Hep Panel. HIV panel, U/A, EKG, Chest X-ray]:** 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.

**Post-op Sling:** 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.