

Case Number:	CM15-0083012		
Date Assigned:	05/05/2015	Date of Injury:	07/20/2014
Decision Date:	07/09/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	04/30/2015

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: Minnesota, Florida
 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 45 year old male, who sustained an industrial injury on July 20, 2014. He reported a severe pulling pain in the right arm that was immediately followed by his feeling weak and right-sided neck, upper, back, mid-back, shoulder, and upper arm pain. The injured worker was diagnosed as having right shoulder internal derangement, right shoulder tendinosis, and right shoulder acromioclavicular joint osteoarthritis. On January 24, 2015, an MRI of the right shoulder revealed acromioclavicular osteoarthritis, supraspinatus tendinosis, and infraspinatus tendinosis. Treatment to date has included physical therapy, chiropractic therapy, acupuncture, steroid injection, and medications including oral pain, topical pain, muscle relaxant, and non-steroidal anti-inflammatory. On February 4, 2015, the injured worker complains of continued right shoulder pain and weakness despite conservative treatment that included physical therapy, chiropractic therapy, acupuncture, steroid injection, and non-steroidal anti-inflammatory. His pain is worse with overhead activity. The physical exam of the right shoulder revealed deltoid complex tenderness, positive Neer and Hawkins- Kennedy tests, mild decreased muscle strength with range of motion, and decreased range of motion. The treatment plan includes a right shoulder diagnostic arthroscopy, possible synovectomy, labral repair, arthroscopic subacromial decompression, distal clavicle excision and rotator cuff repair, pre-op medical clearance, 12 visits of post-operative physical therapy, a post-operative sling, and a post-operative cold therapy unit. The injured worker's current work status was temporarily totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder diagnostic arthroscopy, possible synovectomy, labral repair, arthroscopic subacromial decompression, distal clavicle excision and rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder arthroscopic debridement for arthritis.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, 213. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Diagnostic arthroscopy, labral repair, partial claviclectomy.

Decision rationale: The injured worker is a 45-year-old male with a date of injury of 7/20/2014. Per exam date of 11/12/2014 he sustained an injury to the right side of neck, upper back, mid back, right shoulder and upper arm. The mechanism of injury was from cleaning the interior part of a car's windshield. He stretched his right arm and experienced severe pulling pain. Examination of the right shoulder revealed tenderness over the deltoid complex. Impingement tests were positive. There was 4/5 muscle strength in flexion, extension, abduction, adduction, internal and external rotation. Range of motion was restricted due to pain. Flexion was 100 and abduction 100. Internal and external rotation was 60 each. An MRI scan of the right shoulder was performed on 1/24/2015. This revealed acromioclavicular arthritis, supraspinatus tendinosis, and infraspinatus tendinosis. The report does not comment on the degree of acromioclavicular arthritis and does not comment on any evidence of impingement. No rotator cuff tear was seen. The labrum was unremarkable. A follow-up examination of February 4, 2015 revealed no change in the findings. The MRI results were noted. The documentation indicates that he had received 12 physical therapy treatments and was advised to finish physical therapy. The diagnosis was right shoulder impingement/tendinitis/acromioclavicular arthritis. Surgery was requested. A follow-up note of 3/4/2015 indicated no change in the findings. The injured worker declined a corticosteroid injection. The operative procedure as requested includes diagnostic arthroscopy of the right shoulder. ODG guidelines indicate diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. In this case the imaging is not inconclusive. As such, diagnostic arthroscopy is not supported. The MRI scan did not show any synovial hypertrophy or inflammation in the joint or bursa. As such, the request for synovectomy is not supported. ODG guidelines recommend labral repair for type II and type IV SLAP lesions. The MRI scan did not show any SLAP lesion and as such, the request for labral repair is not supported. For arthroscopic subacromial decompression, California MTUS guidelines indicate 3-6 months of a comprehensive exercise rehabilitation program with 2-3 corticosteroid injections and physical therapy or a supervised home exercise program and documented failure. This has not been documented and as such, subacromial decompression is not supported. California MTUS guidelines recommend a rotator cuff repair for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. The MRI scan did not show any evidence of a rotator cuff tear. As such, the request for a rotator cuff repair is not supported. ODG guidelines indicate partial claviclectomy in the presence of imaging evidence of severe osteoarthritis of the acromioclavicular joint. The MRI scan does mention

osteoarthritis of the acromioclavicular joint but does not indicate the severity of the same. As such, partial claviclectomy is not supported. In light of the above, the request for surgery as stated is not supported by guidelines and the medical necessity of the request has not been substantiated.

Associated surgical services; Pre-operative medical clearance: 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), shoulder (acute and chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, 213. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Diagnostic arthroscopy, partial claviclectomy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical services; post-operative physical therapy: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, 213. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Diagnostic arthroscopy, labral repair, partial claviclectomy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical services; post-operative shoulder sling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, 213. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Diagnostic arthroscopy, labral repair, partial claviclectomy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical services; post-operative cold therapy unit: 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), shoulder (Acute and chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, 212. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Diagnostic arthroscopy, labral repair, partial claviclectomy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.