

Case Number:	CM15-0083028		
Date Assigned:	05/05/2015	Date of Injury:	04/22/2013
Decision Date:	06/26/2015	UR Denial Date:	04/21/2015
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 63 year old female, who sustained an industrial injury on 4/22/13. Initial complaints were not reviewed. The injured worker was diagnosed as having left shoulder impingement syndrome. Treatment to date has included status post medial branch block right third occipital nerve (11/20/14); medications. Diagnostics included MRI left shoulder (11/7/14); MRI cervical spine (12/23/14). Currently, the PR-2 notes dated 4/13/15 indicated the injured worker complains of pain in the left shoulder that radiates to the left arm with frequent spasms in the bicep area and shooting pain to the left pectoralis. She reports severe neck, upper back pain with severe nausea and dizziness. She also has right shoulder overcompensation pain. The injured worker had a left shoulder injection on 3/18/15 of Toradol and lidocaine that was not helpful. Objective findings note left shoulder positive for tenderness and the AC joint is positive for crossover, very guarded and limited range of motion less than 50% of normal. The provider notes that the left shoulder has failed time, medication, injections, home range of motion exercises. The treatment plan includes a request for left shoulder arthroscopy subacromial decompression; Mumford procedure; post-operative physical therapy 12 sessions (3 x weeks for 4 weeks) and pre-operative clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy Subacromial Decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 209-210, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter; Low Back Chapter (Acute & Chronic), Surgical Considerations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211 and 213.

Decision rationale: The requested surgical procedure is subacromial decompression for impingement syndrome. MRI of the left shoulder dated 11/7/2014 revealed mild hypertrophic changes on the inferior aspect of the left acromioclavicular joint. There was no evidence of a rotator cuff tear. However, there were findings suggestive of degeneration and tendinosis of the supraspinatus. And no impingement was documented. A progress note dated 12/3/2014 indicates complaint of neck pain associated with tightness and dizziness and nausea. MRI scan of the cervical spine revealed a broad-based central disc herniation at C3-4 measuring 1-2 mm, broad-based central disc herniation at C4-5 measuring 1-2 mm, broad-based central/left paracentral disc herniation at C5-6 measuring 2 mm with mild central spinal canal stenosis. No nerve root impingement was identified. The clinical diagnoses include vertigo, myofascial pain syndrome and headaches. The most recent progress note of 3/18/2015 indicates subjective complaint of pain in the neck and left shoulder with radiation into the biceps and paresthesias in the second, third, and fourth fingers of the left hand. She was having difficulty with activities of daily living, driving, and sleeping. The neck pain frequently caused headaches. She was taking Norco, Tizanidine, Antivert and Promethazine. On examination there was spasm and tenderness in the paracervicals and neck range of motion was very limited. There was diffuse weakness in the left deltoid, biceps and triceps. Left shoulder had very limited motion with associated tenderness. The documentation also indicates that the injured worker never had physical therapy for the left shoulder. 6 visits were requested for impingement and tendinosis. The subacromial space of the left shoulder was injected with lidocaine and Toradol using ultrasound guidance. The injection did not relieve the pain which indicates that the surgery may not be of benefit. California MTUS guidelines indicate conservative care; including cortisone injections and an exercise rehabilitation program can be carried out for at least 3-6 months before considering surgery. The injured worker had not received any physical therapy for the left shoulder prior to March 18, 2015 per available notes. The pain source has also not been identified. As such, the request for arthroscopy with subacromial decompression is not supported by guidelines and the medical necessity of the request has not been established.

Mumford Procedure: 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), Indications for Surgery - Partial Claviclectomy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Partial claviclectomy (Mumford procedure).

Decision rationale: With regard to the request for Mumford procedure, ODG guidelines are used. The MRI scan of 11/7/2014 revealed mild hypertrophic changes of the inferior aspect of the left acromioclavicular joint. ODG indications for surgery include 6 weeks of conservative care plus pain at the acromioclavicular joint and aggravation of pain with shoulder motion plus tenderness over the acromioclavicular joint and/or pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial plus imaging clinical findings of posttraumatic changes of acromioclavicular joint or severe degenerative joint disease of acromioclavicular joint or complete or incomplete separation of the acromioclavicular joint and bone scan is positive for acromioclavicular joint separation. In this instance the degenerative changes are mild and there is no documentation of relief obtained with an injection of anesthetic for diagnostic therapeutic trial. As such, the request for a partial claviclectomy (Mumford procedure) is not supported by guidelines and the medical necessity of the request has not been substantiated.

Post-operative physical therapy 3x4: 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 clearance: 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.