

Case Number:	CM14-0210056		
Date Assigned:	12/23/2014	Date of Injury:	12/11/2013
Decision Date:	03/09/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/15/2014

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 56-year-old female who reported an injury on 12/11/2013 after lifting a 5 gallon bottle. An unofficial MRI of the right shoulder performed on 02/12/2014, revealed a rotator cuff tendinosis with impingement morphology. The clinical note dated 10/15/2014 noted the injured worker had complaints of significant symptoms regarding the right shoulder. It described pain with any type of reaching or lifting above shoulder height. There was difficulty with activities of daily living including grooming and dressing. She describes nocturnal pain and is unable to lay on her right side. Upon examination there was limited range of motion with painful arc. There was a positive Hawkins and Neer's impingement and a positive empty can test. There was pain reported with cross over test and generalized weakness of the rotator cuff. The provider noted that a cortisone injection would be appropriate however, the patient will not consent to an injection. It was noted that the patient had tried and failed at initially recommended conservative treatment with the exception of an injection. The provider recommended a right shoulder arthroscopy subacromial decompression Mumford procedure. There was no rationale provided. The request for authorization was dated 08/12/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy Subacromial Decompression Mumford Procedure: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery, Acromioplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Partial claviclectomy (Mumford procedure) and Surgery for impingement syndrome.

Decision rationale: The request for right shoulder arthroscopy subacromial decompression Mumford procedure is not medically necessary. The California MTUS/ACOEM Guidelines state that surgery for impingement syndrome is usually arthroscopic decompression. The procedure is not indicated for injured worker with mild symptoms or those who have no activity limitations. Conservative care including cortisone injections can be carried out for at least 3 to 6 months prior to considering surgery. The Official Disability Guidelines further state that indications for surgery include failure to respond to 3 to 6 months of conservative care with subjective findings of pain with arc motion and night pain, plus objective findings of weakness or absent abduction with demonstrated atrophy and tenderness over the rotator cuff or anterior acromial area. There should be evidence of a positive impingement sign and temporary relief of pain with an anesthetic injection. There should be imaging studies, positive of an impingement. Documentation submitted for review lacked evidence of imaging studies that support impingement. The injured worker physical examination indicated the presence of shoulder inflammation. However the guidelines indicate that prior to surgical intervention there should be clear correlation between the pain and objective evidence of its cause. Without objective imaging study evidence, and objective physical evidence of presence of a surgical problem, and without knowledge of the effects of a diagnostic therapeutic shoulder injection, the referenced guidelines would not support surgical intervention. As such, the medical necessity has not been established.

Post-Op Physical Therapy 3x wk x 4wks Right Shoulder: 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 DME: Cold Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery, Acromioplasty

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.