

Case Number:	CM15-0114877		
Date Assigned:	06/23/2015	Date of Injury:	10/11/2014
Decision Date:	08/25/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/15/2015

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 36 year old female who sustained an industrial injury on 10/11/14 involving her left shoulder. The mechanism of injury was not clear. She currently complains of left shoulder pain; neck pain that is popping, grinding which causes her to wake up at night. On physical exam of the left shoulder there was positive impingement (Neer) sign, shrug sign positive, arc pain and greater tuberosity tenderness, acromioclavicular joint tenderness and adduction test positive. She has taken Prednisone. Diagnoses were left shoulder impingement with acromioclavicular joint arthrosis; primary osteoarthritis of the shoulder region; however there was no objective evidence of the same on MRI or ultrasound. Treatments to date include medication; ice; rest; injections for both subacromial space and acromioclavicular joint (1/29/15, 5/4/15) with temporary relief; physical therapy which did not help. Diagnostics include MRI of the left shoulder (11/19/14) (negative for impingement or AC arthritis) and; ultrasound of left extremity soft tissue (1/29/15) which was negative. On 5/27/15 the treating provider's plan of care included a request for left shoulder arthroscopy with acromioplasty; physician assistant, surgical assistant; post-operative shoulder brace and post-operative physical therapy 2X6. UR noncertified the request because of the negative MRI and negative ultrasound citing CA MTUS and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder Arthroscopy with Subacromial decompression, excision distal clavicle:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery ([http:// www.odg-twc.com/odgtwc/shoulder.htm#Surgery](http://www.odg-twc.com/odgtwc/shoulder.htm#Surgery)).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

Decision rationale: The injured worker is a 36-year-old female with a history of left shoulder pain related to a date of injury of 10/10/2014. The clinical impression has been impingement syndrome. However, she did not respond to physical therapy or corticosteroid injections. Diagnostic testing to date has included MRI scan and ultrasound examination of the left shoulder. The MRI scan was entirely negative per radiology report of 11/19/2014. The rotator cuff was intact with normal signal, there was no joint effusion, glenoid labrum was intact, the biceps tendon was in proper position and the acromioclavicular joint was unremarkable. The ultrasound examination of the left shoulder was performed on 1/29/2015 and was again entirely negative. There was no evidence of tendinopathy or tear of the subscapularis, supraspinatus, infraspinatus, or biceps tendon. There was no evidence of impingement. A request for left shoulder arthroscopy with subacromial decompression and excision of the distal clavicle was noncertified by utilization review in light of the negative MRI and ultrasound. The California MTUS guidelines indicate referral for surgical consultation may be indicated for patients who have red flag conditions such as an acute rotator cuff tear, activity limitation for more than 4 months plus existence of is surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. In this case, although the clinical examination is suggestive of impingement, the diagnostic workup has been entirely negative to date including the MRI scan as well as the ultrasound of the shoulder. In the absence of any tendinitis, or evidence of impingement on the imaging studies, a subacromial decompression is not indicated. Furthermore, the diagnostic testing does not show any evidence of acromioclavicular arthritis. As such, resection of the lateral clavicle is not indicated. In light of the foregoing the requests for arthroscopy of the shoulder with subacromial decompression and excision of the distal clavicle are not supported by guidelines and the medical necessity of the request has not been substantiated.

PA (Physician Assistant) assist: 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 operative shoulder brace: 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 operative physical therapy 2 times a week for 6 weeks: 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.