

<b>Case Number:</b>	CM15-0140459		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	09/26/2012
<b>Decision Date:</b>	12/22/2015	<b>UR Denial Date:</b>	07/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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 58-year-old female, who sustained an industrial injury on September 26, 2012. She reported a cumulative trauma injury. The injured worker was diagnosed as status post left trigger thumb release, left carpal tunnel release, left ulnar nerve release at Guyon's canal in the wrist on 09-13-2011, status post right carpal tunnel release on 09-27-2011, status post left ring trigger finger release on 12-31-2012, residual-recurrent left carpal tunnel syndrome, bilateral upper extremity strain-sprain, left shoulder sprain and reported right middle and ring trigger fingers. Treatment to date has included diagnostic studies, medications, and exercise and chiropractic treatment. On November 14, 2014, notes stated that she failed conservative treatment and was not interested in a left carpal tunnel cortisone injection. On August 18, 2014, an EMG and nerve conduction study of left upper extremity and cervical paraspinals showed median motor and sensory prolongation through the left carpal tunnel. Ultrasound of the bilateral shoulders on October 10, 2014, showed a left AV joint hypertrophy-osteophyte formation-narrowing of the subacromial space, left high grade partial thickness rotator cuff tear of the supraspinatus, left long head biceps tendon partial thickness tear of the bicipital groove, left anterior-superior glenoid labrum fraying-degeneration and a right shoulder comparison of mild subacromial impingement-rotator cuff tendinosis. On March 18, 2015, the injured worker complained of left shoulder pain especially with activities. Most of the handwritten progress report was illegible. On July 2, 2015, utilization review denied a request for arthroscopic subacromial decompression, distal clavicle resection, rotator cuff debridement vs. repair for left

shoulder, pre-operative medical clearance evaluation, post-operative therapy twice weekly for four weeks left shoulder and colder therapy unit purchase for left shoulder.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Arthroscopic subacromial decompression, distal clavicle resection, rotator cuff debridement vs. repair, left shoulder,:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter: Partial claviclectomy.

**Decision rationale:** California MTUS guidelines indicate surgery for impingement syndrome is usually arthroscopic decompression. The procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care including cortisone injections can be carried out for at least 3-6 months before considering surgery. The guidelines recommend 3 months of physical therapy continuously or 6 months intermittently with 2-3 corticosteroid injections as part of an exercise rehabilitation program for impingement syndrome, partial-thickness rotator cuff tears and small full-thickness rotator cuff tears. Diagnostic lidocaine injections are also recommended to distinguish pain sources in the shoulder area such as impingement. The medical records submitted do not document such an exercise rehabilitation program with corticosteroid injections. The notes indicate that she declined injections due to a bad experience in the past. The other alternative is Toradol injections. Physical therapy notes have not been submitted. Furthermore, official radiology reports pertaining to the diagnostic testing are also not available. ODG guidelines necessitate documentation of severe acromioclavicular arthritis for lateral claviclectomy. Although the documentation indicates some hypertrophic arthritic changes were noted in the acromioclavicular joint, the severity of the osteoarthritis has not been documented. In light of the foregoing, the request for arthroscopy of the left shoulder with subacromial decompression and partial claviclectomy is not supported and the medical necessity of the request has not been substantiated.

#### **Pre-operative medical clearance evaluation:** 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 therapy, twice weekly for 4 weeks, left 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.

**Associated surgical service: Cold therapy unit, purchase, left 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.