

Case Number:	CM15-0078983		
Date Assigned:	04/30/2015	Date of Injury:	09/17/2014
Decision Date:	06/02/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	04/24/2015

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 50-year-old female with a date of injury of 9/17/2014. She complained of the left shoulder, upper back, and lower back pain. The MRI scan of the left shoulder dated November 6, 2014 revealed a flat, laterally downsloping acromion, mild osteoarthritis of the acromioclavicular joint, tendinosis of the supraspinatus and infraspinatus tendons, subacromial and subdeltoid bursitis, and a small effusion. On March 11, 2015 a follow-up visit and request for authorization is documented. The subjective complaints pertaining to the shoulder are not listed. On examination full range of motion of the shoulder was documented. Strength was 5/5 bilaterally. A detailed examination of the shoulder was not documented; however, there was evidence of impingement. The assessment was left shoulder impingement syndrome. The recommendation was arthroscopic subacromial decompression. The provider stated that she had failed conservative treatment, anti-inflammatories and physical therapy for half a year. However, there is no documentation indicating the number of physical therapy visits and injections, if any, and the response to such treatment. Per examination of April 22, 2015 and appeal for request for orthopedic surgery authorization, the injured worker was complaining of neck pain, low back pain, right hip pain and bilateral shoulder pain. Range of motion of both shoulders was normal. There was full abduction and full forward flexion. Sensation was diminished over bilateral C6 dermatomes. There was a C5-6 disc herniation noted. There was a positive Neer's sign of impingement in both shoulders. The diagnosis was cervical radiculopathy, lumbar radiculopathy, and left shoulder impingement syndrome. The provider is stating that conservative care was provided for more than 6 months but details of the physical

therapy treatments and injections have not been provided. Diagnostic injection for impingement and the results are not documented. A request for "Left shoulder arthroscopy" with unspecified surgical procedures was non-certified by utilization review and is now appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy: 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), Acromioplasty.

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

Decision rationale: California MTUS guidelines indicate surgery for impingement syndrome is 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 2 or 3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. The documentation submitted does not include details of such treatment. The number of physical therapy visits or injections of corticosteroids and the response to such treatment have not been provided. Normal range of motion and strength of the shoulders was documented. The guidelines also recommend a diagnostic subacromial lidocaine injection to distinguish pain sources in the shoulder for example impingement. This is particularly helpful in the presence of cervical spine pathology such as the herniated disc at C5-6 to identify the pain source. The documentation provided does not include a diagnostic injection. Furthermore, the request as stated is for left shoulder arthroscopy and does not specify the surgical procedure that is being requested. In light of the foregoing, the request for shoulder arthroscopy is not supported and the medical necessity of the request has not been substantiated.

Postoperative physical therapy 2 times a week for 8 weeks: 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), Acromioplasty.

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

Decision rationale: Since the primary surgical procedure is not medically necessary, the requested post-operative physical therapy is also not medically necessary.

