

Case Number:	CM13-0059871		
Date Assigned:	12/30/2013	Date of Injury:	09/24/2010
Decision Date:	05/15/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	12/02/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery and Hand Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 42-year-old male who reported an injury on 09/24/2010. The mechanism of injury was not provided for review. The injured worker's treatment history to the right shoulder included physical therapy, injections, oral medications, and activity modifications. The injured worker underwent an MRI on 07/25/2013 that documented a stable long head partial thickness split tear with the intra-articular tenodesis as well as a possible tear near the biceps labral anchor. It was also documented that the injured worker had subscapularis tendinosis with evidence of a possible partial thickness articular or surface tear, stable fatty atrophy at the teres minor musculature, and stable mild to moderate acromioclavicular joint arthrosis. The injured worker was evaluated on 10/01/2013. It was documented that the injured worker continued to have significant pain complaints. However, no physical exam findings were provided for review from that appointment. The injured worker's diagnoses included rotator cuff tear of the left shoulder, and impingement syndrome of the right shoulder. The injured worker was evaluated on 10/21/2013 and it was noted that the injured worker had limited left sided range of motion, left side greater than the right, with weakness to the shoulders bilaterally and tenderness to the subacromial spaces bilaterally. The injured worker's treatment plan included surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

SURGICAL PROCEDURE: RIGHT SHOULDER ARTHROSCOPY, SUBACROMIAL BURSECTOMY, ACROMIOPLASTY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation ODG (Shoulder Chapter).

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

Decision rationale: The requested surgical procedures, right shoulder arthroscopy, subacromial bursectomy and acromioplasty are not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does support shoulder arthroscopy for impingement syndrome when there is clear, clinical examination findings supported by imaging study that have failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the injured worker has persistent weakness and pain that has failed to respond to multiple conservative interventions. There is an imaging study that indicates significant impingement. However, the clinical documentation submitted for review fails to provide any objective evidence of impingement to support the imaging study. There is no quantitative assessment of range of motion, orthopedic tests to support an impingement sign, or a quantitative assessment of weakness that would support a significant limitation in the injured worker's functional capabilities. Without objective evidence of the injured worker's functional limitations, surgical intervention is not supported. As such, the requested surgical procedures, right shoulder arthroscopy, subacromial bursectomy and acromioplasty are not medically necessary or appropriate.

12 POST OP PHYSICAL THERAPY SESSIONS (2X6): 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.