

Case Number:	CM13-0063303		
Date Assigned:	12/30/2013	Date of Injury:	08/18/2009
Decision Date:	05/22/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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 Physician 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 47 year old female with industrial injury 8/18/09. Report of chronic neck pain and bilateral shoulder pain. Exam note 10/25/13 demonstrates chronic neck pain and bilateral shoulder pain. Exam demonstrates decreased bilateral shoulder range of motion with AC joint pain and subacromial pain. Range of motion 150 degrees of abduction and flexion without pain. There is no evidence of motor weakness in bilateral upper extremities. MRI left shoulder 11/17/11 demonstrates mild to moderate rotator cuff tendinosis with small focal partial thickness undersurface tear, supraspinatus bursitis and acromioclavicular degenerative changes. Prior subacromial injections noted on 11/29/11 and 8/27/13 with report of two days relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 LEFT SHOULDER ARTHROSCOPIC DECOMPRESSION AND DISTAL CLAVICLE RESECTION: 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), INDICATIONS FOR SURGERY - ACROMIOPLASY.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), ACROMIOPLASTY, PARTIAL CLAVICULECTOMY (MUMFORD PROCEDURE).

Decision rationale: The California MTUS/ACOEM guidelines are silent on the issue of acromioplasty or distal clavicle resection. The employee does not meet ODG criteria for either acromioplasty or distal clavicle resection. There is insufficient evidence of failure of 6 weeks of conservative care or anesthetic injection into the AC joint. While the employee underwent subacromial injection on 11/29/11 and 8/27/13, there is no documentation of benefit with AC joint injection. In addition there is no evidence of a painful arc from 90-130 degrees to warrant acromioplasty according to the guidelines. Therefore the determination is for non-certification.

12 POST-OPERATIVE THERAPY SESSIONS: 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), INDICATIONS FOR SURGERY - ACROMIOPLASTY.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), ACROMIOPLASTY, PARTIAL CLAVICULECTOMY (MUMFORD PROCEDURE).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.