

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0133634 | | |
| Date Assigned: | 08/29/2014 | Date of Injury: | 06/08/2010 |
| Decision Date: | 10/02/2014 | UR Denial Date: | 07/25/2014 |
| Priority: | Standard | Application Received: | 08/21/2014 |

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 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 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 47 year old female claimant with an industrial injury dated 06/08/10. Patient reports right shoulder pain. The patient has previously had a corticosteroid injection to the right shoulder on 07/10/14 in which did aid in pain relief. Conservative treatments include a home exercise program, physical therapy for the left shoulder pain, and the perscription of Percocet for pain relief. Exam note 07/10/14 states the patient returns with right shoulder pain, and increased pain when the arm is used. The pain was generally in the anterior and lateral area of the shoulder. Physical exam demonstrates that the patient had minimal tenderness in the paraspinal muscles, with weakness in the right deltoid. Range of motion of the right shoulder was listed as a flexion of 160 degrees, abduction of 140 degrees, external rotation of 75 degrees, and internal rotation of 70 degrees. The exam notes demonstrate a postive Neer, Yergason, and Hawkins tests. The patient demonstated a negative empty can test and cross body adduction test. Treatment includes a right shoulder arthroscopy, subacromial decompression, and an acromioplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with subacromial decompression and acromioplast, QTY: 1:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (updated 04/25/14), Surgery for Impingement Syndrome

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Acromioplasty surgery

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 7/10/14. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 7/10/14 does not demonstrate evidence satisfying the above criteria. In addition there is no formal MRI report of the right shoulder for review. Therefore the request is not medically necessary.

Unspecified per-operative x-ray, QTY: 1: 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), Low Back (updated 07/08/14), Preoperative Testing General

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.

Pre-operative labs including CMP (Comprehensive Metabolic Panel), CBC W/DIFF (Complete Blood Count with differential), PT (Prothrombin Time) and PTT (Partial Thromboplastin Time): 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), Low Back (updated 07/08/14), Preoperative Testing General

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.