

Case Number:	CM14-0167981		
Date Assigned:	10/15/2014	Date of Injury:	06/25/2014
Decision Date:	11/19/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/13/2014

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:

51 year old male claimant with an industrial injury dated 06/25/14. Exam note 08/14/14 states the patient underwent a corticosteroid injection to the left shoulder but only provided temporary pain relief. Exam note 09/04/14 states that the patient returns with left shoulder pain. The patient rates the pain a 4-8/10. Upon physical exam the patient was positive subacromial bursitis, impingement, and pain over the AC joint. There was direct palpation visible and pain evident during the cross arm testing. There was palpable crepitus with the left shoulder motion and the patient had 4/5 strength to resistance in all directions. The O'Brien's test was positive and the patient had left paracentral muscle spasm in the trapezius muscle midway between the cervical spine and left shoulder. Treatment includes left shoulder arthroscopic subacromial decompression with distal clavicle resection and evaluation of rotator cuff, physical therapy, and the prescription of Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopic Subacromial Decompression With Distal Clavicle Resection and Evaluation of Rotator Cuff: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Acromioplasty

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 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 9/4/14. 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. Therefore, this request is not medically necessary.

Norco 10/325mg #90: 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.