

Case Number:	CM14-0044429		
Date Assigned:	07/02/2014	Date of Injury:	09/29/2013
Decision Date:	08/05/2014	UR Denial Date:	04/02/2014
Priority:	Standard	Application Received:	04/11/2014

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 claimant is a 39-year-old male with industrial injury reported as 9/29/13. The exam note from 1/15/14 demonstrates report of right shoulder pain and neck pain radiating into right upper extremity. The report of pain noted on flexion, extension and external rotation. The examination note from 3/3/14 demonstrates normal muscle strength with minimal restriction on range of motion. Right shoulder magnetic resonance imaging (MRI) on 10/30/13 demonstrates minimal partial thickness tear, of supraspinatus with labral tear and capsular sprain. Physical therapy notes attached from 10/4/13 and 11/18/13. No anesthetic injection documented in record.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic right shoulder evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Comp, Shoulder (Acute and Chronic), Indications for Surgery.

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), Acromioplasty Surgery.

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

Arthroscopic subacromial decompression, distal clavicle resection, labral and/or cuff debridement versus repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Comp, Shoulder (Acute and Chronic), Indications for Surgery.

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 Chapter, Acromioplasty Surgery.

Decision rationale: According to the CA MTUS 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 Official Disability Guidelines (ODG) shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees, which is not present in the submitted clinical information from 1/15/14 and 3/3/14. Only two visits of physical therapy are present in the records submitted. In addition night pain and weak or absent abduction must be present which is not present in the records. 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 1/15/14 and 3/3/14 does not demonstrate evidence satisfying the above criteria. Therefore, the determination is not medically necessary.