

Case Number:	CM15-0003289		
Date Assigned:	02/25/2015	Date of Injury:	02/13/2014
Decision Date:	04/02/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	01/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 48-year-old female who sustained an industrial injury on 2/13/14, relative to a slip and fall. The progress report from 6/4/14 through 10/17/14 documented treatment focused on the left knee. Activity modification was recommended for the left shoulder. The 11/3/14 left shoulder MRI conclusion documented low-grade partial thickness tear at the junction of the supraspinatus and infraspinatus tendons, with additional bursal surface fraying and mild acromioclavicular joint osteoarthritis. The 11/6/14 treating physician report cited severe left shoulder pain. Physical exam documented limited range of motion with positive impingement signs. The diagnosis included left shoulder partial-thickness rotator cuff tear and end stage left knee osteoarthritis. The treatment plan recommended left shoulder arthroscopic subacromial decompression and debridement. On 12/11/14, utilization review non-certified a left shoulder arthroscopy, subacromial decompression and debridement, noting, Medical Treatment Utilization Schedule Guidelines, American College of Occupational and Environmental Medicine and Official Disability Guidelines was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy, subacromial decompression and debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (updated 10/31/14), Diagnostic arthroscopy / Indications for Surgery -- Rotator cuff repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Conventional x-rays, AP, and true lateral or axillary view. AND MRI, ultrasound, or arthrogram showing positive evidence of impingement are required. Guideline criteria have not been met. The patient presents with right shoulder pain, limited range of motion, and positive impingement signs. There is no documentation relative to specific range of motion loss, painful arc of motion, nighttime pain, rotator cuff or acromial tenderness, rotator cuff weakness, or a positive diagnostic injection test. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.