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| Case Number: | CM15-0106579 | | |
| Date Assigned: | 06/10/2015 | Date of Injury: | 04/23/2012 |
| Decision Date: | 07/13/2015 | UR Denial Date: | 05/18/2015 |
| Priority: | Standard | Application Received: | 06/02/2015 |

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: California, Indiana, Oregon
 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:

This 35 year old female sustained an industrial injury on 4/23/12. She subsequently reported right shoulder pain. Diagnoses include right shoulder impingement syndrome. Treatments to date include MRI testing, physical therapy, TENS therapy and prescription pain medications. The injured worker continues to experience right shoulder pain that radiates down the right arm and into the hand and causes a decrease in range of motion. Upon examination, there were positive impingement signs in the right shoulder with positive supraspinatus sign noted there was crepitus in the right shoulder. Acromioclavicular joint tenderness is negative bilaterally. Right shoulder range of motion is diminished. A request for Right shoulder arthroscopic subacromial decompression, Associated surgical service: Vascutherm and Post Op physical therapy (PT) 3 times 2 was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic subacromial decompression: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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. 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 2/8/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. The most recent MRI does not demonstrate any significant surgical pathology. Based on this the request is not medically necessary.

Associated surgical service: Vascutherm: 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), Shoulder (updated 04/03/15) Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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

Post Op physical therapy (PT) 3 times 2: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

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