

Case Number:	CM15-0188539		
Date Assigned:	10/01/2015	Date of Injury:	08/15/2012
Decision Date:	11/09/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/24/2015

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, Oregon, Washington
 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 52 year old female, who sustained an industrial injury on 8-15-2012. The injured worker was diagnosed as having bilateral internal shoulder derangement status post steroid injection. Treatment to date has included diagnostics, physical therapy, and medications. On 4-28-2015, the injured worker complains of neck pain, rated 7 out of 10, shoulder pain, rated 6-7 out of 10, and arm-hand pain, rated 5 out of 10. Shoulder examination noted positive tenderness over the acromioclavicular joint, intact sensation, no instability, and no swelling or erythema. Neer's tests and supraspinatus tests were positive bilaterally. Exam on 6-09-2015 noted continued complaints of left shoulder pain and decreased range of motion. Exam was "unchanged from last visit". Exam on 7-21-2015 again noted exam "unchanged from last visit". Radiographs of the left shoulder (4-17-2015) showed acromioclavicular osteoarthritis and status post cervical spine fusion. Computerized tomography of the left shoulder (4-17-2015) showed acromioclavicular osteoarthritis, calcific supraspinatus tendinosis, and infraspinatus tendinosis. Magnetic resonance imaging of the left shoulder (4-10-2014) showed supraspinatus and infraspinatus tendinosis versus partial interstitial tendon tears, vertical biceps tendinosis versus partial tendon tear, possible superior labral tear, mild joint effusion, and acromioclavicular osteoarthritis. Magnetic resonance imaging of the right shoulder (4-10-2014) showed supraspinatus tendinosis, possible subscapularis calcific tendinosis, superior labral tear, SLAP type II configuration, and acromioclavicular joint osteoarthritis. Work status was modified, total temporary disability if unavailable. The treatment plan included staged right and left shoulder arthroscopic subacromial decompression with debridement of cuff vs repair if needed and post

operative physical therapy 12 sessions, 3 times a week for 4 weeks after each procedure, 24 visits total. On 8-21-2015 Utilization Review non-certified the requested procedure(s) and post-operative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Staged right and left shoulder Arthroscopic subacromial decompression with debridement of cuff vs repair if needed: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder section, 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 7/21/15. 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 7/21/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is not medically necessary.

Post operative physical therapy 12 sessions 3 times a week for 4 weeks after each procedure, 24 visits total: 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.