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| Case Number: | CM15-0190779 | | |
| Date Assigned: | 10/05/2015 | Date of Injury: | 06/01/2010 |
| Decision Date: | 11/12/2015 | UR Denial Date: | 09/21/2015 |
| Priority: | Standard | Application Received: | 09/28/2015 |

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 69-year-old female, who sustained an industrial-work injury on 6-1-10. A review of the medical records indicates that the injured worker is undergoing treatment for pain in right shoulder joint, right rotator cuff syndrome right shoulder impingement and status post right distal radius fracture in 2012. The previous treatments included pain medications, diagnostics, activity modifications, physical therapy (unknown amount), orthopedic consult, and other modalities. The right shoulder Magnetic Resonance Imaging (MRI) dated 1-13-15 reveals full thickness, full width tearing of the supraspinatus tendon with a gap of 2 centimeters between the stump and retracted torn tendon end. Medical records dated (5-12-15 to 8-25-15) indicate that the injured worker complains of persistent right shoulder pain. She has pain every day to a certain degree all day and it radiates to the upper trapezius. It is increased with cold weather and activity. The pain also radiates into the arm and forearm. She reports restrictions with activities of daily living (ADL). The medical records also indicate worsening of the activities of daily living. Per the treating physician report dated 8-25-15 work status is permanent and stationary with permanent disability. The physical exam dated 8-25-15 reveals that she has pain with lowering and raising the right arm, and there is painful arc at 120 degrees with abduction and 95 degrees with adduction on the right arm. She has a lot of grimace on her face, range of motion is very painful when performed, the empty can sign is positive with pain and spring back arm test is negative but very painful when performed. The physician indicates that she continues to have shoulder pain in the right shoulder and the Magnetic Resonance Imaging (MRI) shows a rotator cuff tear, therefore surgical intervention is recommended. The requested service is Right

shoulder Arthroscopic Subacromial Decompression. The original Utilization review dated 9-21-15 non-certified the request for Right shoulder Arthroscopic Subacromial Decompression as not medically necessary.

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 Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index 11th Edition (web) Shoulder, Surgery for impingement syndrome.

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.

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 8/25/15. 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 8/25/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore, the determination is not medically necessary.