

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0122940 | | |
| Date Assigned: | 07/07/2015 | Date of Injury: | 05/27/2013 |
| Decision Date: | 07/31/2015 | UR Denial Date: | 05/27/2015 |
| Priority: | Standard | Application Received: | 06/25/2015 |

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:

The injured worker is a 57 year-old female who sustained an industrial /work injury on 5/27/13. She reported an initial complaint of bilateral shoulder pain. The injured worker was diagnosed as having right shoulder adhesive capsulitis with extensive synovitis, subacromial impingement syndrome, and chronic biceps tendinitis. Treatment to date includes medication, surgery (right shoulder arthroscopy on 12/12/13), physical therapy, and injections. MRI results were reported on 12/10/13, 9/3/14. Currently, the injured worker complained of left shoulder and arm pain along with right residual discomfort. Per the primary physician's report (PR-2) on 4/15/15, examination revealed severe left shoulder pain secondary to impingement and chronic biceps tendinitis. There is tenderness to palpation over the anterior aspect of the acromion, biceps tendon, positive Speed's, and impingement tests. Current plan of care included medication and shoulder surgery. The requested treatments include left shoulder arthroscopic debridement and subacromial decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic debridement and subacromial decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

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, 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. 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 4/15/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore, the request does not adhere to guideline recommendations and is not medically necessary.