

Case Number:	CM15-0171517		
Date Assigned:	09/11/2015	Date of Injury:	07/22/2015
Decision Date:	10/09/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	08/31/2015

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 53 year old female, who sustained an industrial injury on 7-22-15. The injured worker is undergoing treatment for right shoulder impingement, labral tear and partial thickness rotator cuff tear. Medical records dated 8-18-15 indicate the injured worker complains of right shoulder pain rated 7 out of 10. Physical exam notes right shoulder tenderness to palpation with decreased painful range of motion (ROM) and positive O'Brian's sign. Treatment to date has included anti-inflammatories and magnetic resonance imaging (MRI) reviewed (8-18-15) and "indicates labral tears and partial thickness rotator cuff tear." The record also indicates she has had no physical therapy or injections as of 8-18-15. The original utilization review dated 8-25-15 indicates the request for right shoulder arthroscopy with subacromial decompression is non-certified noting 3-6 month trial of failed non-operative care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with subacromial decompression: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Surgery for Impingement Syndrome; Indications for Surgery -- Acromioplasty.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

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 8/18/15. 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 8/18/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is for non-certification. The request is not medically necessary.