

Case Number:	CM15-0079114		
Date Assigned:	04/30/2015	Date of Injury:	11/01/2011
Decision Date:	06/03/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	04/24/2015

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, 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 58-year-old male, with a reported date of injury of 11/01/2011. The diagnoses include right shoulder partial rotator cuff tear in the setting of the os acromiale. Treatments to date have included an MRI of the right shoulder on 02/06/2015 and 01/29/2013, right shoulder arthroscopy, and oral medications. The medical report dated 03/05/2015 is somewhat of poor quality. The report indicates that the injured worker complained of right shoulder pain. The injured worker had a right shoulder arthroscopy three years prior, and there was some initial improvement after the procedure. There was a history of right shoulder weakness that was fairly typical of bursitis and impingement symptoms including pain with forward elevation, internal rotation, and reaching behind the back. The physical examination showed mild tenderness over the acromioclavicular (AC) joint; tenderness along the aspect of the acromion and laterally; deficit of strength with abduction, forward flexion, and subluxation; positive impingement sign to internal rotation; full range of motion in the shoulder; normal strength in the biceps and triceps; and normal neurovascular status. The MRI of the right shoulder dated 02/06/2015 showed interstitial tendon tearing in the setting of moderate tenderness at the supraspinatus tendon as well as mild to moderate osteoarthritic changes at the AC joint exerting mild mass effect on the rotator cuff in the setting of the os acromiale. The treating physician requested right shoulder revision subacromial decompression, rotator cuff debridement versus repair, possible labral repair and surgical assistant. On 03/26/2015, Utilization Review denied the request because there was no indication that the injured worker

had 3-6 months of continuous conservative treatment for this condition; the presence of night pain was not documented; no documentation of his response to physical therapy and CSI.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder revision subacromial decompression, rotator cuff debridement versus repair, possible labral repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. 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 that is not present in the submitted clinical information from 2/2/15. 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 2/2/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is not medically necessary.

Associated surgical services: Surgical assist: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.