

Case Number:	CM15-0097017		
Date Assigned:	05/27/2015	Date of Injury:	04/22/2014
Decision Date:	07/01/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/19/2015

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 49 year old female, who sustained an industrial injury on 4/22/2014, while employed as a cook. She reported neck and shoulder pain from repetitive work duties. The injured worker was diagnosed as having cervical sprain/strain with myofascitis, left shoulder impingement and bursitis, rule out rotator cuff tear, and thoracic sprain/strain. Treatment to date has included diagnostics, modified work, physical therapy, acupuncture, and medications. Currently, the injured worker complains of constant bilateral shoulder pain, with numbness and tingling to her bilateral upper extremities. Movements were painful and limited, she was right hand dominant, and work status was total temporary disability. She stated that pain could be as high as 10/10 at times. She declined cortisone injection and current medication regime was not documented. Exam of the right and left shoulders noted tenderness to palpation in the trapezius and in the superior and anterior aspects. Hawkin's and Neer tests were positive. Magnetic resonance imaging of the left shoulder (3/27/2015) showed inferior aspect of the acromioclavicular joint, causing flattening of the distal supraspinatus muscle. Magnetic resonance imaging of the right shoulder was also documented. The left shoulder was documented as more symptomatic, despite more findings in the right shoulder on magnetic resonance imaging. The treatment plan included left shoulder surgery, consisting of arthroscopic subacromial decompression, with possible rotator cuff repair, pre-operative medical clearance, a sling, post-operative cold therapy unit for 10 days, and post-operative physical therapy for the left shoulder (2x6).

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder surgery consisting of arthroscopic subacromial decompression with possible rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Surgery for Impingement Syndrome; Official Disability Guidelines (ODG), Indications for Surgery, Acromioplasty, Rotator cuff repair.

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 4/2/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is for non-certification.

Associated Surgical Service: Post-op cold therapy unit for 10 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, Cryotherapies.

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.

Associated Surgical Service: Post-op physical therapy left shoulder 2 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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.