

Case Number:	CM14-0056479		
Date Assigned:	08/08/2014	Date of Injury:	11/01/2011
Decision Date:	09/02/2015	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	04/26/2014

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 (IW) is a 41-year-old female who sustained an industrial injury on 11-01-2011. Diagnoses include bilateral shoulder strain, sprain and right shoulder tendinosis, impingement syndrome, rotator cuff tear and labral tear (per medical records). Treatment to date has included medications, extracorporeal shockwave therapy, injections, chiropractic treatment and physical therapy. According to the Doctor's First Report of Occupational Injury or Illness dated 12-4-2013, the IW reported headaches, neck pain, bilateral upper extremity pain, psychiatric complaints and sleeping problems. On examination, the right shoulder was tender to palpation, range of motion was decreased and Neer's sign, Codman's sign and supraspinatus test was positive. Sensation was decreased in the right anterolateral shoulder and arm; motor strength was decreased in the bilateral upper extremities at 4 over 5. A request was made for surgery: right shoulder arthroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

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. 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 notes do 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.