MAXIMUS Federal Services

Case Number:	CM14-0104708		
Date Assigned:	07/30/2014	Date of Injury:	12/16/2013
Decision Date:	09/22/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/07/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 51 years old female with an injury date on 12/16/2013. Based on the 06/18/2014 progress report provided by [redacted], the diagnosis is frozen shoulder. According to this report, the patient complains of frozen shoulder that is feeling better. Per physician, patient received a corticosteroid injection May of 2014. Shoulder active range of motion is 95-100 % normal. The 05/07/2014 report indicates the left shoulder active range of motion is 50% normal and passive range of motion is 60-65% normal. MRI of the left shoulder on 01/21/2014 reveals moderate grade interstitial tear of the anterior to central portion of the left supraspinatus tendon, tear of the anterior labrum, mild osteoarthritis of the left acrominoclaviculat joints, a mildly laterally downsloping orientation of the acromion and thickening and edema in the inferior glenohumeral joint capsule. The MRI report was not provided in the file. There were no other significant findings noted on this report. The utilization review denied the request on 06/30/2014. [redacted] is the requesting provider, and he provided treatment reports from 03/07/2014 to 06/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Physician assistant: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official disability Guidelines, shoulder.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

21 day rental of continuous passive motion machine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Regarding continuous passive motion, the Official Disability Guidelines state it is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Furthermore, the ODG states that it is not recommended after shoulder surgery or for nonsurgical treatment. Review of reports does not show the patient has adhesive capsulitis to indicate a 21 day rental of continuous passive motion machine. As such, the request is not medically necessary.

left shoulder arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, indications for surgery - rotator cuff.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Regarding arthroscopic surgery for impingement, the Official Disability Guidelines require conventional x-rays, AP, and true lateral or axillary view and Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff. Furthermore, the ODG states the subjective and objective findings should indicated pain with active arc motion 90 to 130 degrees, pain at night, weak or absent abduction; may also demonstrate atrophy, tenderness over rotator cuff or anterior acromial area, positive impingement sign, and temporary relief of pain with anesthetic injection (diagnostic injection test). In this case, one can assume the patient has failed conservative care, but there is no documentation of how the patient responded to the injection; objective findings do not include weak or absent abduction and no conventional x-rays showed positive evidence of impingement to qualify for an arthroscopic decompressive surgery. As such, the request is not medically necessary.