

Case Number:	CM14-0019945		
Date Assigned:	04/23/2014	Date of Injury:	11/19/2010
Decision Date:	07/14/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/18/2014

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 Orthopaedic Surgery 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:

This 60-year-old male driver sustained a left shoulder injury on 11/19/10 loading a truck with boxes. Right shoulder compensatory injury is noted. The patient is status post left shoulder arthroscopic decompression on 5/10/11, and left shoulder manipulation under anesthesia on 1/3/12. Physical therapy was completed in April 2012 with improved range of motion noted. The 7/11/12 left shoulder MRI noted no re-tear in the cuff. The 1/13/14 orthopedic consultation report cited current moderate sharp left shoulder pain, worsened with overhead activity. Exam findings noted shoulder elevation 115 degrees, internal rotation 20 degrees, and external rotation 80 degrees with acromioclavicular joint tenderness, positive crossover test, and normal rotator cuff strength. X-rays revealed near bone on bone arthritis in the AC joint and type II acromion. The diagnosis was rotator cuff syndrome. The treating physician opined the patient had signs and symptoms consistent with left shoulder AC joint pain, not treated with the first surgery, and adhesive capsulitis. A request for left shoulder arthroscopic distal clavicle excision and capsular release, possible cuff debridement versus repair, with associated post-operative items was submitted. The treating physician stated that the patient would not get better with more time, more physical therapy, more injections, or more pills. The 1/29/14 utilization review recommended denial of the left shoulder arthroscopy based on static range of motion since 2012, no provocative findings for AC arthrosis, no documentation of a diagnostic injection into the AC joint, and an absence of conservative treatment. The 1/30/14 treating physician progress report noted that the patient had 3 separate AC joint injections over 2013 with temporary relief. The 3/6/14 treating physician appeal documented the patient had 3 AC joint injections in 2013 with temporary benefit, an AC joint injection in February 2014 with 10% improvement, pain at 90

degrees and increased with elevation, +3 AC joint tenderness, no effusion or crepitus, normal strength, and no instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPY, DISTAL CLAVICLE EXTENSION AND CAPSULAR RELEASE, POSSIBLE DEBRIDEMENT VS REPAIR: Upheld

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

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

Decision rationale: Under consideration is a request for left shoulder arthroscopy, distal clavicle extension and capsular release, possible debridement vs. repair. The California MTUS guidelines do not provide recommendations for surgery in chronic cases. The Official Disability Guidelines for acromioplasty generally require 3 to 6 months of conservative treatment directed toward gaining full range of motion, pain with active arm motion 90-130 degrees, pain at night, weak or absent abduction or atrophy, rotator cuff or anterior acromial tenderness, positive impingement sign, positive diagnostic injection test, x-rays, and positive imaging evidence of rotator cuff deficiency. The ODG state surgery for adhesive capsulitis is under study, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment has been tried and failed. Recent physical therapy directed towards gaining full range of motion has not been attempted. There is no rotator cuff weakness or indication of nighttime pain. There is no positive imaging evidence of rotator cuff deficiency. Therefore, this request for left shoulder arthroscopy, distal clavicle extension and capsular release, possible debridement vs. repair is not medically necessary.

SLING: Upheld

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

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.

COLD THERAPY UNIT RENTAL X7 DAYS: Upheld

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

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.

PHYSICAL THERAPY X12 SESSIONS: Upheld

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

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.

NSAID'S: Upheld

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

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.

NARCOTICS: Upheld

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

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.

ASSISTANT SURGEON: Upheld

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

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.