MAXIMUS Federal Services

Case Number:	CM14-0133784		
Date Assigned:	08/27/2014	Date of Injury:	12/20/2012
Decision Date:	09/22/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/21/2014

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 Occupational Medicine 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:

Injured worker is a male with date of injury 12/20/2012. Per the primary treating physician's progress report dated 5/28/2014, Th e injured worker is a 52-year-old male with complaints referable to his cervical lumbar, left shoulder and right knee. He reports that his left shoulder has worsened. He continues to perform his exervcise program. He continues to complain of 7/10 pain in the left shoulder and has difficulty sleeping due to discomfort. He is currently not taking any pain medications. He is currently temporarily totally disabled. On examination of the left shoulder there are healed arthroscopic portal scars. Strength is decreased by pain and there is diffuse tenderness. There is limited and painful shoulder motion. Diagnoses include 1) status post left long head of the biceps tenodesis, left endoscopic subacromial decompression, arthroscopic excision distal left clavicle, arthroscopic supraspinatus tendon tear repair DOS 1/21/2014 2) postop frozen left shoulder 3) diabetes mellitus.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MANIPULATION OF LEFT SHOULDER UNDER ANESTHESIA AND POSSIBLE DIAGNOSTIC ARTHROSCOPY WITH CAPSULAR RELEASE AND REPAIR OF DAMAGED STRUCTURES AS INDICATED: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, SHOULDER (ACUTE& CHRONIC).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Manipulation Under Anesthesia (MUA) section, Surgery for Adhesive Capsulitis section.

Decision rationale: The MTUS Guidelines does not address surgery for adhesive capsulitis. The Official Disability Guidelines (ODG) reports that surgery for adhesive capsulitis and manipulation under anesthesia are under study. The clinical course of this condition is considered self-limiting, and conservative treatment is a good long term treatment regimen for adhesive capsulitis. There is some evidence, however, to support arthroscopic release of adhesions for cases failing conservative treatment. Manipulation under anesthesia may be considered in cases that are refractory to conservative therapy lasting at least 3-6 months where range of motion remains significantly restricted (abduction less than 90 degrees). The clinical reports state that the left shoulder range of motion is restricted, but does not describe the severity of the restriction. The injured worker's surgery was also only four months prior to this request, and appears to be premature without providing an explanation of why the surgery is necessary now when conservative measures may not have been exhausted. The request for one manipulation of left shoulder under anesthesia and possible diagnostic arthroscopy with capsular release and repair of damaged structures as indicated is not medically necessary and appropriate.

22 PHYSICAL THERAPY SESSIONS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, SHOULDER (ACUTE& CHRONIC).

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

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

CRYOTHERAPY AND SHOULDER ABDUCTION SLING: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Manipulation Under Anesthesia (MUA) section, Surgery for Adhesive Capsulitis section.

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

CBC, CMP, PT, PTT: 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 chapter, Manipulation Under Anesthesia (MUA) section, Surgery for Adhesive Capsulitis section.

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

1 EKG: 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 chapter, Manipulation Under Anesthesia (MUA) section, Surgery for Adhesive Capsulitis section.

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