

Case Number:	CM14-0185025		
Date Assigned:	11/12/2014	Date of Injury:	10/07/2011
Decision Date:	12/15/2014	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/06/2014

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 Orthopedic 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:

According to the records made available for review, this is a 48-year-old female with a 10/7/11 date of injury. At the time (10/23/14) of request for authorization for one left shoulder lysis and sub-acromial decompression, one surgical assistant, pre-operative labs with EKG, and thirty post-operative physical therapy sessions, there is documentation of subjective (ongoing severe left shoulder pain, occasionally awakens the injured worker at night) and objective (tenderness over the anterior aspect of the left shoulder, very limited and guarded range of motion, forward flexion to 40, abduction to 40 degrees, limited internal and external rotation) findings, imaging findings (left shoulder MRI (7/2/14) report revealed supraspinatus moderate insertional tendinosis, mild synovial thickening of subacromial bursa), current diagnoses (rotator cuff syndrome and adhesive capsulitis), and treatment to date (activity modification, home exercise program and medications (Vicodin)). 10/6/14 medical report identifies that the injured worker declines a cortisone injection. There is no documentation of additional subjective clinical findings: pain with active arc motion 90 to 130 degrees; additional objective clinical findings: atrophy and tenderness over rotator cuff or anterior acromial area, positive impingement sign, and temporary relief of pain with anesthetic injection (diagnostic injection test); and conservative treatment (physical therapy and NSAIDs).

IMR ISSUES, DECISIONS AND RATIONALES

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

One Left Shoulder Lysis and Sub-Acromial Decompression: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Subacromial Decompression; Surgery for Adhesive Capsulitis

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. In addition, ODG identifies documentation of conservative treatment (physical therapy and NSAIDs) as criteria necessary to support arthroscopic release of adhesions. Within the medical information available for review, there is documentation of diagnoses of rotator cuff syndrome and adhesive capsulitis. In addition there is documentation of subjective clinical findings: pain at night objective clinical findings: weak abduction. Furthermore, given documentation of imaging findings (left shoulder MRI identifying supraspinatus moderate insertional tendinosis, mild synovial thickening of subacromial bursa), there is documentation of imaging clinical findings: MRI showing positive evidence of deficit in rotator cuff. However, there is no documentation of additional subjective clinical findings: pain with active arc motion 90 to 130 degrees; additional objective clinical findings: atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); and conservative treatment (physical therapy and NSAIDs). Therefore, based on guidelines and a review of the evidence, the request for one left shoulder lysis and sub-acromial decompression is not medically necessary.

Associated Surgical Service: One Surgical Assistant: 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), Shoulder (Acute & Chronic) Chapter

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.

Associated Surgical Service: Pre-Operative Labs with Electrocardiography (EKG): 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), Low Back - Lumbar and Thoracic (Acute & Chronic) Chapter

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.

Associated Surgical Service: Thirty Post-Operative 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 (ODG), Low Back - Lumbar and Thoracic (Acute & Chronic) Chapter

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.