MAXIMUS Federal Services

Case Number:	CM14-0099031		
Date Assigned:	07/28/2014	Date of Injury:	07/08/2005
Decision Date:	08/29/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/27/2014

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 Pennsylvania. 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 is a 61-year-old, male, janitor, who sustained a vocational injury on 07/08/05. The records provided for review document that the claimant underwent right shoulder arthroscopic selective posterior capsular release, subacromial decompression, excision of the coracoacromial ligament, along with Mumford procedure on 07/19/11 followed by s second right shoulder procedure on 07/31/12 which included an arthroscopic global capsular release, redo subacromial decompression with excision of the coracoacromial ligament and remnant. The report of X-rays of the right shoulder performed on 02/26/14 showed Type I postoperative acromion configuration consistent with acromioplasty, evidence of adequate Mumford resection, normal acromiohumeral interval and normal appearing glenohumeral joint with concentric reduction on axillary lateral projection. The report of the MRI of the right shoulder dated 03/27/14 identified postoperative conjoined tendons with a supra and infraspinatus muscles. Intermediate mottled signal seen could be postoperative suggestive also of some underlying mild tendinopathy. There was no tear of the rotator cuff or biceps labral complex. The MRI showed a small amount of fluid in the subacromial bursa. The office visit of 07/08/14 noted chronic pain in the right shoulder, wrist, and hand as well as the side of his neck. Examination showed motor testing of the right upper extremity was limited due to guarding and pain. Sensation was intact to the right upper extremity. The claimant's current working diagnosis was residual right shoulder impingement syndrome status post multiple surgeries of the right shoulder. Conservative care to date includes Norco, Relafen, Robaxin, Flector patch, Lyrica, and formal physical therapy. This request is for right shoulder arthroscopic decompression and capsular release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic Decompression Capsule Release for Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (updated 04/25/14).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder chapter: Surgery for adhesive capsulitis.

Decision rationale: The California ACOEM Guidelines and supported by the Official Disability Guidelines do not recommend Arthroscopic Decompression Capsule Release for the Right Shoulder as medically necessary. The medical records provided for review fail to establish the medical necessity of the requested procedure due to the fact that there is no recent abnormal physical exam objective findings establishing that the claimant has ongoing pathology in the right shoulder which may be amendable to surgery. The medical records also fail to establish that the claimant has had an exhaustive course of continuous conservative treatment which should consist of corticosteroid injection therapy prior to considering and recommending surgical intervention. Therefore, based on the documentation presented for review, and in accordance with California MTUS, ACOEM, and Official Disability Guidelines the request for the right shoulder arthroscopic decompression and capsular release cannot be considered medically necessary.

Postoperative Physical Therapy for the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The request for the right shoulder arthroscopic decompression and capsular release cannot be considered medically necessary. Therefore, the request for postoperative physical therapy for the right shoulder is also not medically.