

Case Number:	CM14-0204468		
Date Assigned:	01/28/2015	Date of Injury:	12/07/2013
Decision Date:	02/28/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	12/04/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Minnesota, Florida
 Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 53-year-old female with a date of injury of 12/7/2013. Documentation from August 11, 2014 indicates the diagnosis of left shoulder impingement syndrome with adhesive capsulitis. The recommended treatment was a corticosteroid injection and physical therapy 2 times a week for 6 weeks. According to the primary treating physicians progress report dated 10/6/2014 she complained of left shoulder pain, improved by about 80% for the first 2 weeks and now complained about the same type of pain. On examination there was a positive impingement sign. There was tenderness over the anterolateral and lateral aspect of acromion. There was weakness of shoulder abduction and external rotation. Passive range of motion of the left shoulder was 140 of flexion, and 120 of abduction, 10 of internal rotation, 70 of external rotation, 20 of adduction and 20 of extension. The patient was diagnosed with left shoulder impingement syndrome with adhesive capsulitis. Left shoulder arthroscopy with subacromial decompression and debridement and manipulation under anesthesia with possible capsular release was requested. An MRI scan of the left shoulder dated 4/26/2014 documented a full-thickness tear of the anterior fibers of the supraspinatus tendon with 11 mm of medial retraction. There was glenohumeral joint effusion noted and fluid within the subacromial and subdeltoid space. There was acromioclavicular joint hypertrophy. There were no other significant findings noted. Per primary treating physician's progress report dated 10/22/2014 the MRI of the left shoulder was brought in by the patient and read by the primary physician as showing increased signal within the supraspinatus tendon and infraspinatus tendon consistent with tendinitis with fluid in the subacromial space consistent with bursitis but no full-thickness rotator cuff tear.

Examination at that time revealed decreased range of motion of the left shoulder, positive impingement sign, and weakness of left shoulder flexion, abduction, external rotation, and internal rotation. A request for authorization for left shoulder arthroscopy with arthroscopic subacromial decompression and debridement, manipulation under anesthesia and possible capsular release dated 10/22/2014 is noted. The surgical request was noncertified on 10/31/2014 as there was insufficient information about conservative treatment of the left shoulder with reference to rehabilitation, the number of visits and outcome, use of oral and injectable medications and the outcome, the specific treatment of mild adhesive capsulitis and outcome, the MRI scan did not reveal adhesive capsulitis but demonstrated a rotator cuff tear with no impingement. Therefore the request for manipulation under anesthesia, arthroscopy and capsular release with debridement was noncertified at this time as it was not medically necessary and appropriate. This is now appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy with subacromial decompression and debridement, manipulation under anesthesia and possible capsular release: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, Topic: Manipulation under anesthesia.

Decision rationale: California MTUS guidelines indicate surgical considerations if there is failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. The MRI scan has revealed a full-thickness rotator cuff tear involving the anterior fibers of the supraspinatus. However, the surgery requested is manipulation under anesthesia, arthroscopic subacromial decompression and debridement and possible capsular release. A rotator cuff repair is not requested. ODG guidelines do not indicate manipulation under anesthesia unless abduction is limited to 90 or less. The documentation provided does not indicate that to be the case. Only one corticosteroid injection was documented. The subsequent notes document a good result from the injection. The guidelines also indicate 3-6 months of conservative treatment where the range of motion remains significantly restricted with abduction less than 90. With regard to subacromial decompression for impingement syndrome, MTUS guidelines indicate 3-6 months of a conservative rehabilitation program of exercises along with 2-3 corticosteroid injections. This has not been documented. Based upon the above, the request for manipulation under anesthesia, arthroscopic subacromial decompression and debridement, and possible capsular release is not supported by guidelines and as such, the medical necessity of the request is not substantiated.

Post-op follow up appointment: 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.

Post-op physical therapy, 12 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.

Associated Surgical Service: Motorized cold therapy unit: 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.

Associated Surgical Service: DVT unit: 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.

Associated Surgical Service: CPM machine: 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.

Associated Surgical Service: Ultra sling with abduction pillow: 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.

Associated Surgical Service: Pain pump: 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.

RN assessment for post-op wound care and home aid as needed: 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.

Pre-op medical clearance with internal medicine: 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.