

Case Number:	CM14-0207570		
Date Assigned:	12/19/2014	Date of Injury:	11/18/2011
Decision Date:	02/28/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	12/11/2014

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: Utah, California
 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:

This injured worker is a 42-year-old male with a reported date of injury of 11/18/2011. His diagnoses included partial rotator cuff tear. The injured worker has completed 6 sessions of formal physical therapy for his bilateral shoulders, with no real relief in regard to the left shoulder. Conservative modalities of rest, ice, anti-inflammatories, analgesics, home stretching, and strengthening exercise for his left shoulder. Diagnostic studies included knee MRI, noted to be normal; left hand MRI, normal; left spine MRI shows multilevel disc degeneration at L5-S1; cervical spine MRI shows multilevel degenerative disc disease, right shoulder full thickness rotator cuff tear in 02/2012, status post diagnostic and operative arthroscopy of the right shoulder on 11/15/2013, showing 25% of partial rotator cuff tear; right knee MRI study shows medial meniscal tear; left shoulder MRI showing partial cuff tear with impingement; EMG studies showing carpal tunnel syndrome semi surgical incision with erythema and warm to the right shoulder status post completion of the Keflex with no residual symptoms. Surgical history included right shoulder diagnostic/operative arthroscopy on 11/15/2013. On 01/14/2015, the injured worker presented for an orthopedic re-evaluation regarding his right shoulder. He continues to experience deficits regarding his range of motion. He stated a couple of weeks ago he began to experience limitations in his mobility. Upon physical examination of the right shoulder, it showed a well healed arthroscopy portals with range of motion from 0 to 150 degrees of forward flexion and abduction, with stiffness and pain, internal rotation is 2 inches away from the SI joint. Physical examination of the left shoulder showed forward flexion and abduction is full, and external rotation is full. Positive for Neer's and Hawkin's impingement, positive

McMurray's and Apley's compressions tests. His current medications are Celebrex and omeprazole. The treatment plan is to request 12 sessions of physical therapy, to complete 2 times a week for the next 6 weeks, as well as a Dynasplint for his right shoulder to help his rehabilitation process. And, also requesting physical therapy for the lumbar spine, as he also has underlying pathology in that regard. The rationale is the patient has developed adhesive capsulitis. The patient has exhausted all of the conservative treatment for the acromioplasty. A Request for Authorization form dated 10/29/2014, was included.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Diagnostic/Operative Arthroscopic Debridement with Acromioplasty: 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) Online Shoulder Chapter-Diagnostic Arthroscopy

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

Decision rationale: The request for left shoulder diagnostic/operative arthroscopic debridement with acromioplasty is not medically necessary. The patient presented on 10/22/2014, for re-evaluation regarding his bilateral shoulders. The guidelines state the patient should undergo conservative care for 3 to 6 months. According to the documentation, the patient has completed conservative modalities of rest, ice, anti-inflammatories, analgesics, home stretching and strengthening exercises. He has also completed at least 12 sessions of formal physical therapy. The physical findings of the left shoulder showed forward flexion and abduction is full, and external and internal rotation is full range of motion. Rotator cuff tear and impingement were supported by the positive Neer and Hawkins signs. However, there was no documentation of failed steroid injections. The MRI completed on 02/08/2012, showed partial tear of the rotator cuff with tendinitis and moderate impingement syndrome. The MRI does not describe where the rotator cuff tear is. The injured worker does not have findings failed steroid injections to support the surgery. As such, the request for left shoulder diagnostic operative arthroscopic debridement with acromioplasty is not medically necessary.

Resection of coracoacromial Ligament and Bursa as indicated: 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, Acromioplasty.

Decision rationale: The request for resection of the coracoacromial ligament and bursa is not medically necessary. The patient presented on 10/29/2014, with complaints of left shoulder pain. There was no objective documentation regarding the coracoacromial ligament and bursa. The coracoacromial ligament and bursa were not mentioned in the MRI. There is no evidence to support this. Therefore, the request for resection of the coracoacromial ligament and bursa is not medically necessary.

Possible Distal Clavicle Resection with Possible Rotator Cuff Repair as Indicated: 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, Acromioplasty.

Decision rationale: The request for Possible Distal Clavicle Resection with Possible Rotator Cuff Repair as Indicated is not medically necessary. The patient presented on 10/22/2014, for re-evaluation regarding his bilateral shoulders. The guidelines state the patient should undergo conservative care for 3 to 6 months. According to the documentation, the patient has completed conservative modalities of rest, ice, anti-inflammatories, analgesics, home stretching and strengthening exercises. He has also completed at least 12 sessions of formal physical therapy. The physical findings of the left shoulder showed forward flexion and abduction is full, and external and internal rotation is full range of motion. There were no positive impingement signs, and no temporary relief of pain with anesthetic injections. The MRI completed on 02/08/2012, showed partial tear of the rotator cuff with tendinosis and moderate impingement syndrome. The MRI does not describe where the rotator cuff tear is. The injured worker does not have objective clinical findings to support the surgery. As such, the request for Possible Distal Clavicle Resection with Possible Rotator Cuff Repair as Indicated is not medically necessary.

Associated Surgical Service: 12 Post-Op Physical Therapy: 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: Medical Clearance: Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), Prothrombin Time (PT), Partial Thromboplastin Time (PTT), Hep Panel, HIV Panel, Urinalysis (UA): 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: Electrocardiography (EKG),: 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: Chest X-Ray: 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: Post-Op 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.

Associated Surgical Service: 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.

Physical Therapy for the Lumbar Spine (unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for physical therapy for the lumbar spine unspecified is not medically necessary. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. There was a lack of documentation indicating the injured worker's prior course of physical therapy, as well as the efficacy of the prior therapy. Since it is an unspecified diagnosis, the amount of physical therapy visits is unclear. Injured workers are instructed and expected to continue active therapies at home as an extension of treatment process in order to maintain improvement levels. The request did not indicate how many or what the physical therapy was indicated for. As such, the request is not medically necessary.