

Case Number:	CM15-0109747		
Date Assigned:	06/16/2015	Date of Injury:	02/03/2009
Decision Date:	08/31/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/08/2015

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: California, Indiana, Oregon
 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 61 year old male who sustained an industrial injury on 02/03/2009. Mechanism of injury was a motor vehicle accident. Diagnoses include left shoulder bursitis and tendinitis; status post left shoulder surgery, left shoulder fibrosis, history of rib fractures, right 5, 6, and 7 with residual rib pain, history of calf contusion, and history of deep vein thrombosis of the lower extremity. Treatment to date has included diagnostic studies, medications injections, physical therapy and status post left shoulder arthroscopic subacromial decompression, Mumford, subscapularis tendon repair on 11/12/2014. Medications include Omeprazole, Alendronate Sodium tablets and Vitamin D. A physician progress note dated 05/05/2015 documents the injured worker complains of left shoulder pain rated a 6-8 out of 10, and can increase with activities. He has trouble lifting his left arm up to shoulder level. The pain radiates to the left side of the torso as well as to the left arm, hand and fingers with prolonged activity. He has occasional numbness and tingling to the left middle, ring and small fingers during the day at work. He has decreased strength in the left hand. On examination left shoulder range of motion is restricted in all planes. There is mild tenderness anterior and at the biceps tendon. Treatment requested is for left shoulder biceps tendon sheath injection, postoperative physical therapy 5 times a week for 2 weeks followed by 2 times a week for 6 weeks for the right shoulder, preoperative labs: complete blood count (CBC), CHEM-7, and Electrocardiogram (EKG), right shoulder arthroscopic subacromial decompression and manipulation under anesthesia, and right shoulder subacromial injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder biceps tendon sheath injection: 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.

Decision rationale: According to CA MTUS/ACOEM guidelines 2nd edition, Chapter 9, Shoulder complaints, page 204, Initial care, subacromial injection may be indicated after conservative therapy for two to three weeks. ODG shoulder is referenced for additional guidance. Steroid injections are recommended. There is insufficient evidence that routine use of ultrasound results in improved patient outcomes. Recommended for: Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; Pain interferes with functional activities (eg, pain with elevation is significantly limiting work). In this case, the pain is documented as mild. Steroid injection is not medically necessary.

Right shoulder subacromial injection: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 204.

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

Decision rationale: According to CA MTUS/ACOEM guidelines 2nd edition, Chapter 9, Shoulder complaints, page 204, Initial care, subacromial injection may be indicated after conservative therapy for two to three weeks. ODG shoulder is referenced for additional guidance. Steroid injections are recommended. There is insufficient evidence that routine use of ultrasound results in improved patient outcomes. Recommended for: Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; Pain interferes with functional activities (eg, pain with elevation is significantly limiting work). In this case, the guideline criteria are met for right shoulder subacromial injection. The request is medically necessary.

Right shoulder arthroscopic subacromial decompression and manipulation under anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of surgery for adhesive capsulitis. Per ODG shoulder section, the clinical course of this condition is self-limiting. There is insufficient literature to support capsular distention, arthroscopic lysis of adhesions/capsular release or manipulation under anesthesia (MUA). The requested procedure is not recommended by the guidelines and therefore is not medically necessary.

Postoperative physical therapy 5 times a week for 2 weeks followed by 2 times a week for 6 weeks for the right shoulder: 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.

Preoperative labs: complete blood count (CBC), CHEM-7, and Electrocardiogram (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.