

Case Number:	CM15-0187204		
Date Assigned:	10/02/2015	Date of Injury:	10/17/2014
Decision Date:	12/16/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	09/23/2015

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 60 year old female, who sustained an industrial-work injury on 10-17-14. A review of the medical records indicates that the injured worker is undergoing treatment for left shoulder chronic grade III acromioclavicular joint (AC) separation and small tear of the supraspinatus tendon. Medical records dated (6-22-15 to 9-3-15) indicate that the injured worker complains of constant continued moderate to severe left shoulder pain with limited range of motion and function, pain and difficulty with activities of daily living (ADL), difficulty with sleeping on the left side and frequent popping in the left shoulder. The injured worker reports that the medications decrease the pain about 30 percent. The medical records also indicate worsening of the activities of daily living. Per the treating physician report dated 9-3-15 the injured worker has not returned to work. The physical exam dated 9-3-15 reveals decreased range of motion of the left shoulder, increased tenderness to palpation left bicipital groove, left acromial space, increased impingement sign, and decreased strength left shoulder and biceps. There is positive Neer's, positive Hawkin's, positive impingement and positive Speed's test left shoulder. The physical therapy notes indicate that the injured worker continues to exhibit limitations in left shoulder range of motion. The physician indicates that the injured worker has failed conservative treatment left shoulder physical therapy 10 sessions, extensive home exercise program (HEP), activity modifications, and injection. The physician indicates that surgical intervention is recommended. Treatment to date has included pain medication, diagnostics, and physical therapy at least 10 sessions, home exercise program (HEP), activity modifications, off work, injection and other modalities. Magnetic resonance imaging (MRI) of the left shoulder

dated 5-28-15 reveals moderate amount of fluid within the subacromial -subdeltoid bursa suggesting bursitis. No calcifications are seen. There is a small joint effusion at the glenohumeral articulation. There is mild to moderate distal supraspinatus tendinopathy and discrete full-thickness tear of the rotator cuff tendon is not present. There is no labral tear identified. The request for authorization date was 9-3-15 and requested services included Left shoulder, arthroscopy subacromial decompression, lysis of adhesions removal of calcific deposit, Associated Surgical Services: Surgical assistant, Post-operative physical therapy, left shoulder, 12 sessions, Associated Surgical Services: Continuous passive motion (device), 3 week rental and Associated Surgical Services: Cold therapy (device), 7 day rental. The original Utilization review dated 9-10-15 non-certified the request for Left shoulder, arthroscopy subacromial decompression, lysis of adhesions removal of calcific deposit, Associated Surgical Services: Surgical assistant, Post-operative physical therapy, left shoulder, 12 sessions, Associated Surgical Services: Continuous passive motion (device), 3 week rental and Associated Surgical Services: Cold therapy (device), 7 day rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder, arthroscopy subacromial decompression, lysis of adhesions removal of calcific deposit: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

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). In this case there is evidence of decreased range of motion indicative of adhesive capsulitis in the examination notes submitted for review. The requested procedure is not recommended by the guidelines and therefore is not medically necessary.

Associated Surgical Services: Surgical assistant: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Surgical assistant.

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post operative physical therapy, left shoulder, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Postsurgical Treatment 2009.

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Surgical Services: Continuous passive motion (device), 3 week rental: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - Continuous passive motion (CPM).

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Surgical Services: Cold therapy (device), 7 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - Continuous-flow cryotherapy.

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.