MAXIMUS Federal Services

Case Number:	CM15-0188965		
Date Assigned:	10/01/2015	Date of Injury:	03/03/2014
Decision Date:	12/16/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/25/2015

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
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 44 year old female, who sustained an industrial injury on 03-03-2014. She has reported subsequent neck and bilateral shoulder pain and was diagnosed with cervical and bilateral shoulder strain, impingement syndrome of the right shoulder, distal clavicle arthrosis on the right, traumatic rotator cuff tear and glenoid labral tears of the right shoulder. MRI of the right shoulder on 07-24-2014 showed moderate distal anterior supraspinatus tendinosis with bursal surface fraying and reactive bursitis. Recent progress notes indicate that x-rays of the right shoulder and right humerus were noted to show no increase in osteoarthritis. Date of the x-rays was not documented. Treatment to date has included medication, at least 24 visits of physical therapy, injections and surgery which were noted to have failed to significantly relieve the pain. The injured worker had diagnostic and operative arthroscopy of glenohumeral joint with debridement of rotator cuff and glenoid labral tear of the right shoulder, arthroscopic acromioplasty, resection of coracoacromial ligament and subacromial bursa of the right shoulder and arthroscopic resection of distal clavicle of the right shoulder performed on 03-11-2015. In a 06-15-2015 progress note the physician indicated that the injured worker was continuing to experience moderate right shoulder pain and was not progressing with self-directed exercise but had been helped with physical therapy. Objective findings showed decreased range of motion of the right shoulder. In a 07-01-2015 progress note the injured worker reported 8 out 10 worsening right shoulder pain and objective findings showed limited range of motion of the right shoulder. Work status was documented as modified with no use of the right upper extremity. In a progress note dated 08-12-2015 the injured worker was noted to be doing poorly with nearly no range of

motion of the right shoulder. Objective examination findings revealed tenderness of the right shoulder with a severe loss of range of motion. The physician noted that the injured worker was severely disabled with almost no range of motion of the right shoulder and that despite non-operative treatment with physical therapy, medications, injections and rest, she remained disabled. The physician noted that authorization was being requested to proceed with a diagnostic and operative arthroscopy of the right shoulder. A request for authorization of arthroscopic right shoulder with capsule release, lysis of adhesions, manipulation under anesthesia, possible biceps tendon tenodesis, assistant PA, post-operative PT 3 times a week for 4 weeks, IF unit 30 day rental, cold therapy unit purchase, pain pump purchase and associated services lab work including CBC, BMP, PT, PTT, UA and EKG was submitted. As per the 09-04-2015 utilization review, the aforementioned requests were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic right shoulder with capsule release, lysis of adhesions, manipulation under anesthesia, possible biceps tendon tenodesis: Upheld

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

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

Decision rationale: CA MTUS/ACOEM Guidelines are silent on the issue of surgery for adhesive capsulitis. According to the ODG Shoulder section, surgery for adhesive capsulitis, "Under study. The clinical course of this condition is considered self-limiting, and conservative treatment (physical therapy and NSAIDs) is a good long-term treatment regimen for adhesive capsulitis, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment." The guidelines recommend an attempt of 3-6 months of conservative therapy prior to contemplation of manipulation and when range of motion remains restricted (abduction less than 90 degrees). In this case there is insufficient evidence of failure of conservative management in the notes submitted from 8/12/15. Until a conservative course of management has been properly documented, the determination is for not medically necessary.

Associated Services: Assistant PA: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Surgeons.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.aaos.org/about/papers/position/1120.asp.

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

Post-operative PT 3 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

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

Associated Services: Lab Work: CBC: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement.

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

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

Associated Services: Lab Work BMP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for clinical systems improvement.

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

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

Associated Services: Lab Work PT/PTT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement.

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

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

Associated Services: Lab Work UA: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Information for Clinical Systems Improvement.

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

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

Associated Services: EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems.

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

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

Associated Services: IF Unit 30 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

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

Associated Services: Cold therapy unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical 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, Continuous flow cryotherapy.

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

Associated Services: Pain pump purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical 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, Postoperative pain pumps.

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