

Case Number:	CM15-0196489		
Date Assigned:	10/12/2015	Date of Injury:	09/10/2014
Decision Date:	12/04/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/06/2015

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 45 year old female, who sustained an industrial-work injury on 9-10-14. A review of the medical records indicates that the injured worker is undergoing treatment for right shoulder rotator cuff disruption with adhesive capsulitis. Treatment to date has included pain medication including Voltaren, Ultram and Protonix, diagnostics, right shoulder injections times 3 with benefit but symptoms returned, physical therapy at least 6 sessions, and other modalities. Magnetic resonance imaging of the right shoulder dated 1-7-15 reveals full thickness tear of the distal supraspinatus tendon, small glenohumeral joint effusion, moderate amount of fluid in the subacromial -subdeltoid bursa and additionally the fluid tracks from the bursa to the intermuscular fascial plane consistent with a leaking bursa, and minimal glenohumeral and acromioclavicular joint (AC) degenerative changes. Medical records dated (5-11-15 to 9-14-15) indicate that the injured worker complains of constant pain and weakness in the right shoulder with inability to lift the right arm and stiffness in the neck. The medical records also indicate that she experiences substantial limitations as a result of her painful and weak injured right shoulder. Per the treating physician report dated 9-14-15 the injured worker may resume full duty as of this time. The physical exam dated 9-14-15 reveals that there is minimal tenderness about the lateral aspect of the right shoulder, Hawkin's and impingement sign are positive on the right, and there is persistent weakness of the supraspinatus on the right. The physician indicates that she was referred for a second opinion in regards to the right shoulder and was recommended to have right shoulder arthroscopy. However, in the interim her shoulder condition has improved somewhat. The request for authorization date was 9-15-15 and requested services included Right

Shoulder Arthroscopy, Subacromial Decompression, Manipulation under Anesthesia and Possible Rotator Cuff Repair, Surgical Assistant, Post-Op Percocet 5-325mg, #60, Post-Op Physical Therapy for the Right Shoulder (24-sessions, 2 times a week for 12-weeks), Post-Op ARC Brace and Post-Op Cold Compression Unit (7-day rental). The original Utilization review dated 9-28-15 non-certified the request for Right Shoulder Arthroscopy, Subacromial Decompression, Manipulation under Anesthesia and Possible Rotator Cuff Repair, Surgical Assistant, Post-Op Percocet 5-325mg, #60, Post-Op Physical Therapy for the Right Shoulder (24-sessions, 2 times a week for 12-weeks), Post-Op ARC Brace and Post-Op Cold Compression Unit (7-day rental).

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy, Subacromial Decompression, Manipulation under Anesthesia and Possible Rotator Cuff Repair: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation ODG Shoulder, Manipulation Under Anesthesia (MUA).

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 the injured worker is diagnosed with rotator cuff tear and some degree of adhesive capsulitis based on the exam of 9/14/15. The treatment for adhesive capsulitis is self-limiting based on the referenced guidelines. The requested procedure is not recommended by the guidelines and therefore the combined procedure is not medically necessary.

Surgical Assistant: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 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-Op Percocet 5/325mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary. Decision based on Non-MTUS Citation ODG Pain, Opioids, specific drug list; Opioids, Criteria for Use.

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-Op Physical Therapy for the Right Shoulder (24-sessions, 2 times a week for 12-weeks): Upheld

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

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-Op ARC Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder, Postoperative abduction pillow sling; Compression Garments.

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-Op Cold Compression Unit (7-day rental): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 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.