

Case Number:	CM15-0050640		
Date Assigned:	04/09/2015	Date of Injury:	09/01/2008
Decision Date:	05/19/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	03/17/2015

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, Sports Medicine

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 67-year-old male who reported an injury on 09/10/2008. The mechanism of injury was not specifically stated. The current diagnoses include complete rupture of the rotator cuff, adhesive capsulitis of the shoulder, rotator cuff sprain, and other affections of the shoulder region. The surgical history includes a left shoulder arthroscopy on 11/03/2008 and a right shoulder arthroscopy on 08/11/2011. The injured worker presented on 01/29/2015 for a follow-up evaluation regarding left shoulder pain, stiffness, and weakness. The injured worker reported no improvement in symptoms. In addition, the injured worker reported insomnia secondary to pain, as well as difficulty performing activities of daily living. The injured worker was no longer participating in physical therapy; however, did participate in a home exercise program weekly. The injured worker was not utilizing any medication. Upon examination of the left shoulder, there was 150 degrees active abduction with a painful arc of motion, positive impingement sign, 170 degrees forward flexion, 15 degree internal rotation contracture, and 4/5 supraspinatus weakness with mild pain noted on isolation and loading. Treatment recommendations at this time included a left shoulder arthroscopy with bursoscopy, capsular release, glenohumeral debridement, and possible redo decompression. The injured worker was also issued a prescription for Norco 10/325mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopic Redo Capsule Release; Glenohumeral Debridement; Subacromial Decompression and other corrections as indicated: 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); Surgery for Adhesive Capsulitis; Indications for Surgery - acromioplasty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 210.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. In this case, it is noted that the injured worker had failed to respond to conservative treatment, including exercise and injection therapy. However, there were no updated imaging studies provided for this review. Therefore, the injured worker does not currently meet criteria for the requested procedure. As such, the request is not medically appropriate.

Bursoscopy: 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.

Pre-op Labs (unspecified) and EKG: Upheld

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

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.

Pre-op Chest X-ray: Upheld

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

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.

Post-op Physical Therapy x 12: Upheld

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

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.