

<b>Case Number:</b>	CM15-0087674		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	11/07/2014
<b>Decision Date:</b>	06/12/2015	<b>UR Denial Date:</b>	04/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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 59 year old male who sustained an industrial injury on November 7, 2014. He has reported injury to the left shoulder and has been diagnosed with rotator cuff tear of the left shoulder and impingement of the shoulder. Treatment has included medications, medical imaging, and physical therapy. Objective findings showed the left shoulder as guarded on flexion. Passive flexion was painful to 90 degrees. MRI of the left shoulder showed intrasubstance tear of the subscapularis, a small partial thickness articular sided supraspinatus tear with 2 cm of retraction, multiple subchondral cysts in the humeral head as well as adjacent to the bicipital groove, degenerative labral tear, and hypertrophy of the AC joint with subchondral bone edema and cyst formation imprinting on the rotator cuff. The treatment request included medication, surgery, and MRI of the left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prescription of Oxycodone 20:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 4/7/15. Therefore the determination is not medically necessary.

**One arthroscopic subacromial decompression, lysis of adhesion, extensive debridement, and manipulation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210.

**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 clinical information from 4/7/15 does not show evidence of adhesive capsulitis. Therefore the request is not medically necessary.

**Associated service: One MRI of the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 208-9.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 207-208.

**Decision rationale:** According to the CA MTUS/ACOEM guidelines Chapter 9 Shoulder complaints regarding imaging of the shoulder, page 207-208 recommends imaging for red flag symptoms, physiologic evidence of tissue insult or neurovascular dysfunction or failure to progress in a strengthening program. In addition, imaging such as MRI would be appropriate for clarification of anatomy prior to an invasive procedure. None of the criteria has been satisfied based upon the MRI of 3/10/15 without interval change in symptoms. Therefore the request for MRI of the shoulder is not medically necessary and appropriate.