MAXIMUS Federal Services

Case Number:	CM15-0115081		
Date Assigned:	06/23/2015	Date of Injury:	08/31/2012
Decision Date:	09/09/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	06/15/2015

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 63 year old male, who sustained an industrial injury on 8/31/12. He reported initial complaints of right shoulder and low back pain after a fall injury. The injured worker was diagnosed as having cervical/thoracic/lumbar spine sprain/strain; right shoulder impingement; right upper extremities neuropathy; lumbar spine radiculopathy; acromioclavicular joint osteoarthritis; labral tear; rotator cuff tendinopathy. Treatment to date has included physical therapy (x24); status post L5-S1 transforaminal bilateral epidural steroid injection/ epidurogram/neuroplasty (5/24/13; 6/27/13); right shoulder injections (x2); medications. Diagnostics included MRI cervical spine (10/25/12; MRI lumbar spine (10/5/12); MRI right shoulder (10/25/12); EMG/NCV study bilateral upper extremities (7/24/13). Currently, the PR-2 notes dated 5/22/15 indicated the injured worker complains of constant bilateral leg weakness; constant lower back pain radiating upwards to upper back pain; constant right shoulder pain radiating downwards to hand; on and off insomnia and injured worker also reports a lump and pulsating on lower back pain. The notes document the lumbar spine was tender with muscle spasms at L1-5 and the cervical spine was tender with muscle spasms at C2-7. The medications are listed as Anaprox 550mg; Valium 5mg; Prilosec 20mg and Tylenol #3. Other documentation in the file indicates the injured worker has a clinical history of diabetes. A QME report dated 2/16/15 reviewed a MRI of the right shoulder dated 10/25/12. It documents the MRI impression as a rotator cuff tendinosis and bursal sided fraying at the anterior margin of the supraspinatus tendon without high-grade tendon tear or tendon retraction. There is subacromial/subdeltoid bursitis. Labral tear consistent with a SLAP lesion. There is small paralabral cyst formation anteriorly and also likely intraosseous extension of the paralabral

cyst at the superior glenoid evidence of adhesive capsulitis. The requested surgery is noted to have been denied prior on two separate occasions. The provider is requesting authorization at this time for Right shoulder arthroscopic subacromial decompression; anesthesia; EKG; Urine Toxicology screen; Related surgical service: Pre-operative blood work: CMP/eGFR, PT, UA/RflCul, CBC/Diff, APTT, ABO/Rh and post-operative physical therapy twice weekly for six weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic subacromial decompression: 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), Indications for Surgery - Acromioplasty Section.

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 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, the treating physician has diagnosed adhesive capsulitis and abduction is not less than 90 degrees. The request is not medically necessary.

Related surgical service: EKG: 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.

Related surgical service: Anesthesia Mark Hestron MD: 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.

Related surgical service: Urine toxicology screen: 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.

Related surgical service: Pre-operative blood work: CMP/eGFR, PT, UA/RflCul, CBC/Diff, APTT, ABO/Rh: 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.

Related surgical service: Post-operative physical therapy, twice weekly for six weeks: 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.