

Case Number:	CM15-0118705		
Date Assigned:	06/29/2015	Date of Injury:	04/21/2015
Decision Date:	08/25/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	06/19/2015

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: Minnesota, Florida
 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 54 year old female who sustained a cumulative industrial injury on 04/21/2015. The injured worker was diagnosed with right rotator cuff syndrome/adhesive capsulitis. Treatment to date has included magnetic resonance arthrogram (MRA) on May 14, 2015, conservative measures, physical therapy and medications. According to the primary treating physician's progress report on May 29, 2015, the injured worker continues to experience right shoulder pain and stiffness. Examination of the cervical spine was negative. The right shoulder examination demonstrated tenderness to palpation over the acromioclavicular joint and laterally over the deltoid. There was significantly decreased range of motion documented. A significant positive Neer's, Hawkins and horizontal cross arm adduction test was documented. Sensation and reflexes were intact with decreased motor strength in abduction and external rotation of the right shoulder. Current medications were not documented. Treatment plan consisted of surgical intervention with right shoulder arthroscopy with subacromial decompression, rotator cuff repair and distal clavicle resection and post-operative physical therapy three times a week for four weeks. The IW also has evidence of adhesive capsulitis with restricted range of motion documented. PT dates provided are from 4/27/2015 through 6/12/2015 but notes have not been provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder scope with SAD: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), indications for surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211, 213.

Decision rationale: The injured worker has clinical evidence of impingement syndrome which is also evident on the MR Arthrogram. Surgery for impingement syndrome is usually arthroscopic decompression. However, the guidelines necessitate documentation of a trial/failure of an exercise rehabilitation program consisting of 2-3 subacromial injections of local anesthetic and cortisone preparation and 3 months of physical therapy continuously or 6 months intermittently with a home exercise program. Diagnostic Lidocaine injections are also recommended to distinguish pain sources in the shoulder area such as impingement. The documentation provided indicates that physical therapy was started on 4/27/2015 and 3 months had not been completed at the time of this application and the results were not known. Furthermore, results of any injections were also not documented. As such, the medical necessity of the requested arthroscopy with subacromial decompression cannot be determined.

RCR (rotator cuff repair): 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), rotator cuff repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topics: Surgery for rotator cuff repair, Surgery for adhesive capsulitis, Manipulation under anesthesia.

Decision rationale: California MTUS guidelines indicate rotator cuff repair is indicated for significant tears that impair function and acute tears in younger workers. Conservative treatment is usually suggested initially including an exercise rehabilitation program for 3 months. In this case there is evidence of adhesive capsulitis which also necessitates conservative treatment. ODG guidelines for rotator cuff repair include criteria for repair with the diagnosis of full-thickness rotator cuff tears in the absence of a frozen shoulder syndrome. For adhesive capsulitis the guidelines indicate that the clinical course is considered self-limiting and physical therapy, NSAIDs, and injections are recommended for 3 months with surgery including arthroscopic release of adhesions and/or manipulation under anesthesia for cases resistant to conservative treatment. As such, it will be necessary to determine the outcome of the exercise rehabilitation program with corticosteroid injections and physical therapy before the requested rotator cuff repair and any possible surgery for adhesive capsulitis is carried out. In light of the above, the medical necessity of the rotator cuff repair cannot be determined at this point.

DCR (Distal Clavicle Resection): 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), shoulder surgery.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Partial claviclectomy.

Decision rationale: ODG guidelines for a partial claviclectomy indicate conservative care for at least 6 weeks, subjective clinical findings of pain at the acromioclavicular joint, objective clinical findings of tenderness and pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial plus imaging clinical findings of severe degenerative joint disease of the acromioclavicular joint. In this case, the documentation provided does not indicate a diagnostic therapeutic trial with an injection of local anesthetic into the acromioclavicular joint. Furthermore, since the primary surgical procedure is not being performed at this time, the request for the associated surgical procedure of partial claviclectomy is not applicable.

Post operative physical therapy evaluation/treatment (initial 3x4): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, 213.

Decision rationale: Since the primary surgical procedure is not medically necessary, none of the associated surgical requests are medically necessary.