

Case Number:	CM13-0005523		
Date Assigned:	11/08/2013	Date of Injury:	12/30/2011
Decision Date:	05/12/2014	UR Denial Date:	07/17/2013
Priority:	Standard	Application Received:	08/01/2013

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. The expert reviewer is Board Certified in Orthopedic Surgeon and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 39-year-old gentleman injured 12/30/11. Records indicate an injury to the right shoulder. Records for review include an MRI report of the right shoulder from April 14, 2012, showing supraspinatus tendinosis and a posterior superior glenoid labral tear with cystic lesion to the glenoid notch indicative of a paralabral cyst. The most recent clinical follow up report is 11/14/13 orthopedic assessment with [REDACTED] indicating continued subjective complaints of pain about the right shoulder, worse with activity. Physical examination findings that date demonstrate positive Neer testing, pain with cross body impingement, positive Hawkins test, and restricted motion with flexion, extension, abduction and internal rotation at endpoints. There was no documentation of weakness. The claimant was diagnosed with a SLAP lesion and per the 2012 MRI recommendations at that time were for cervical intervention to include a shoulder arthroscopy with partial distal clavicle excision, acromioplasty, extensive debridement and possible rotator cuff repair. There is no formal documentation for a SLAP repair or debridement noted. There are also multiple requests for a preoperative assessment, postoperative use of acupuncture, chiropractic measures, compressive devices and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY WITH PARTIAL DISTAL CLAVICLE RESECTION (MUMFORD), PARTIAL ANTEROLATERAL ACROMINOPLASTY WITH RESECTION OF COROCORACROMION LIGAMENT, EXTENSIVE

DEBRIEDMENT SUBACROMIAL BURSA, POSSIBLE ROTATOR CUFF REPAIR.:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The California ACOEM Guidelines, supported by Official Disability Guidelines criteria, would not currently support the surgical process requested. The claimant's imaging is noted to be with labral tearing and a mild degree of inflammatory change to the supraspinatus. Records in this case do not indicate specific acromioclavicular joint findings or rotator cuff tearing. The specific request in this case was for a distal clavicle resection, subacromial decompression with rotator cuff repair. The surgical request would fail to correlate with the claimant's prior imaging. The claimant is also with lack of documentation of recent conservative measures including no recent documentation of injection care. The acute need for surgery as specifically stated in this case would not be supported by the guidelines. Therefore, the requested services are not medically necessary at this time.

A PULMONARY FUNCTION TEST: 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.

INTERFERENTIAL CURRENT (IFC) UNIT INCLUDING SUPPLIES: 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.

A PAIR OF COMPRESSION STOCKINGS: 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.

A SHOULDER ABDUCTION BRACE: 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.

NORCO 5/325MG #60: 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.

12 SESSIONS OF ACUPUNCTURE: 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.

**12 SESSIONS OF POST-OPERATIVE CHIROPRACTIC
MANIPULATION/PHYSIOTHERAPY:** 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-OPERATIVE 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.

HOT/COLD UNIT: 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.

KEFLEX 500MG #20: 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.

**PREOPERATIVE LABS TO INCLUDE: CBC, CHEM 12, PROTHROMBIN TIME (PT), PARTIAL THROMBOPLASTIN TIME (PTT) AND UA GLUCOSE, URINALYSIS
DRUG 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.