

Case Number:	CM13-0011694		
Date Assigned:	12/27/2013	Date of Injury:	01/03/2013
Decision Date:	06/09/2014	UR Denial Date:	07/16/2013
Priority:	Standard	Application Received:	08/15/2013

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 Surgery, 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:

This is a 65-year-old female with a reported industrial injury dated 1/3/13. An MRI of the right shoulder dated 2/26/13, demonstrates tear of superior and anterior/superior labrum. A report demonstrates intact rotator cuff and mild osteoarthritis of the right acromioclavicular joint. The exam note dated 5/21/13, demonstrates persistent symptoms in shoulder despite physical therapy. An exam of the shoulder demonstrates forward flexion of 130 degrees, external rotation of 40 degrees and internal rotation to mid lumbar level. Documentation is noted of the completion of eleven (11) physical therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER DECOMPRESSION WITH DEBRIDEMENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 204, 209. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER CHAPTER.

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

Decision rationale: The ACOEM Guidelines recommend activity limitation of more than four (4) months plus the existence of a surgical lesion. In this case, there is insufficient evidence of

activity modification for four (4) months or evidence of rotator cuff tear on the MRI from 2/26/13. Therefore, the determination is for non-certification for right shoulder decompression with debridement.

POSSIBLE LABRAL REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 209. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SURGERY FOR SLAP LESIONS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, SURGERY FOR SLAP LESIONS.

Decision rationale: According to the Official Disability Guidelines criteria, labral repair is recommended for Type II lesions and Type IV lesions if more than 50% of the tendon is involved. In this case, the MRI of the shoulder from the note dated 2/26/13 does not adequately characterize the type of labral tear. Therefore, the determination is for non-certification.

POSSIBLE ROTATOR CUFF REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 204, 209. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER CHAPTER.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, ROTATOR CUFF REPAIR.

Decision rationale: According to the Official Disability Guidelines criteria, surgery for rotator cuff repair requires weakness in the abduction testing and MRI findings demonstrating evidence of a deficit in rotator cuff tear. As this information is not present in the exam notes and MRI dated 2/26/13, determination is for non-certification.

DISTAL CLAVICAL EXCISION: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, PARTIAL CLAVICULECTOMY.

Decision rationale: According to the Official Disability Guidelines criteria, at least six (6) weeks of conservative care must be directed towards symptom relief. In addition, there must be evidence of tenderness over the acromioclavicular (AC) joint and/or relief from anesthetic

injection. In this case, none of the listed criteria is present in the records. The patient has mild AC joint changes on an MRI dated 2/26/13, and the exam dated 5/21/13, which does not demonstrate positive findings on examination to warrant the surgical procedure. Therefore the determination is for non-certification.

ASSISTANT SURGEON: 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.

POST-OPERATIVE PHYSICAL THERAPY (2) TIMES A WEEK FOR (6) 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.

KEFLEX 500MG QID #12: 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.

ZOFRAN 4MG: 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 7.5/325MG #50: 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.

VITAMIN C 500MG QD #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.

IBUPROFEN 600MG TID #90: 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.

COLACE 100MG BID #10: 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.