

Case Number:	CM14-0049467		
Date Assigned:	08/08/2014	Date of Injury:	09/01/2011
Decision Date:	09/11/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	04/17/2014

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, has a subspecialty in 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 patient is a 56-year-old gentleman who injured the right shoulder in a work related accident on 09/01/11. Records provided for review that are specific to the right shoulder include a progress report dated 02/27/14 documenting a request for shoulder arthroscopy to include subacromial decompression and Mumford procedure. The surgical recommendation was based upon the physical examination findings of 01/21/14 that showed chronic shoulder pain, atrophy, tenderness to palpation at the acromioclavicular joint and biceps tendon with restricted range of motion and positive impingement maneuvers. The report also documented that failed conservative care included physical therapy, rest and medication management. There was no documentation of prior injection therapy. The report of an MRI performed in May 2012 identified down sloping acromion and mild degenerative changes of the acromioclavicular joint, but no other clinical findings.

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 AND MUMFORD PROCEDURE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: Shoulder Procedure -Partial Claviclectomy (Mumford Procedure)ODG Indications for Surgery -- Partial Claviclectomy.

Decision rationale: Based on California MTUS ACOEM Guidelines and supported by the Official Disability Guidelines, the proposed surgery is not recommended. The ACOEM Guidelines recommend that conservative care, including cortisone injections, be carried out for at least three to six months before considering surgery. Records for review fail to demonstrate three to six months of conservative care including injection therapy has been followed. In addition, the patient's imaging study is from 2012 and fails to show any evidence of acute clinical pathology to the rotator cuff and only mild degenerative changes at the acromioclavicular joint. Therefore, the right shoulder subacromial decompression and Mumford Procedure is not medically necessary.

MOTORIZED HOT/COLD UNIT FOR 7 DAYS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205,555-556.

Decision rationale: The proposed surgery is not recommended as medically necessary. Therefore, the request for use of a cryotherapy device is also not medically necessary.

PRO SLING ABDUCTON PILLOW: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: Shoulder Procedure -Postoperative Abduction Pillow Sling.

Decision rationale: The proposed surgery is not recommended as medically necessary. Therefore, the request for use of a postoperative sling is also not medically necessary.

PHYSICAL THERAPY RIGHT SHOULDER 2 X 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The proposed surgery is not recommended as medically necessary. Therefore, the request for postoperative physical therapy is also not medically necessary.

SOLAR CASE HEATING SYSTEM 6-8 HRS PER DAY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp , 18th Edition, 2013 Updates: Shoulder Procedure - Thermotherapy.

Decision rationale: The proposed surgery is not recommended as medically necessary. Therefore, the request for use of solar case heating is also not medically necessary.

AMBIEN 10 MG 1 PO HS #30 2 REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: Pain Procedure -Zolpidem (Ambien®).

Decision rationale: The proposed surgery is not recommended as medically necessary. Therefore, the request for use of Ambien is also not medically necessary.

FLEXERIL 10 MG 1 PO Q 8 HRS 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxer.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63.

Decision rationale: The proposed surgery is not recommended as medically necessary. Therefore, the request for use of Flexeril in the postoperative setting is also not medically necessary.

SPRIX NASAL SPRAY 15.75 MG: 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 Non-MTUS Procedure - Sprix (Ketorolac Tromethamine Nasal Spray).

Decision rationale: The proposed surgery is not recommended as medically necessary. Therefore, the request for use of Sprix Nasal Spray in the postoperative setting is also not medically necessary.