

Case Number:	CM14-0095547		
Date Assigned:	08/04/2014	Date of Injury:	06/18/2007
Decision Date:	09/29/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/23/2014

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 Orthopaedic 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 56-year-old male sustained an industrial injury on 6/18/07. The mechanism of injury was not documented. The 3/17/08 right shoulder MRI impression documented articular undersurface partial thickness tear of the infraspinatus tendon, degeneration and tendinosis of the supraspinatus tendon, anterior enthesophyte extending from the acromion, mild acromioclavicular joint arthritis, and degeneration of the superior labrum suggestive of a chronic SLAP tear. The 3/14/14 physical therapy progress report documented no improvement in right shoulder range of motion or strength from 2/4/14 to 3/14/14. The 5/9/14 treating physician report cited continued and worsening right shoulder pain. Difficulty was reported with activities and sleeping on his right side. The last MRI was performed on 3/17/08. Right shoulder physical exam documented abduction and external rotation weakness. There was exquisite tenderness over the AC joint and the anterolateral aspect of the acromion. Flexion, adduction, and internal rotation caused accentuated pain. The diagnosis included cubital tunnel syndrome bilaterally, partial right shoulder supraspinatus tendon tear, clinical right shoulder impingement syndrome, clinical AC cartilage disorder right shoulder, and right shoulder clinical subacromial/subdeltoid bursitis. The treatment plan recommended a shoulder MRI prior to surgery but this had been denied. Right shoulder arthroscopy was recommended including partial Mumford procedure, partial anterolateral acromioplasty with resection of coracoacromial ligament, extensive debridement subacromial bursa, possible repair rotator cuff, and intra-scalene block under ultrasound guidance for control of post operative pain. Multiple post-operative and pre-operative requests were submitted. The 6/4/14 utilization review denied the request for right shoulder surgery and associated pre-operative and post-operative services/items pending updated imaging. The request for right shoulder MRI and follow-up was certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Keflex 500mg #20: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Bratzler DW, Dellinger EP, Olsen KM, Perl TM, Auwaerter PG, Bolon MK, Fish DN, Napolitano LM, Sawyer RG, Slain D, Steinberg JP, Weinstein RA. Clinical practice guidelines for antimicrobial prophylaxis in surgery. Am J Health Syst Pharm. 2013 Feb 1;70(3):195-283.

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

Tramadol 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Tramadol Page(s): 76-80, 93-94, 113.

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use. Opioids, specific drug list Page(s): 76-80, 91.

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

Physical Therapy 2 x 6 visits (Right Shoulder): Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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

Acupuncture 2 x 6 visits (Right Shoulder): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

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

Pre Op Labs: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

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

Right Shoulder Arthroscopy: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: MTUS Guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months; failure to increase range of motion and shoulder muscle strength even after exercise programs; and clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Guideline criteria has not been met in this case. The most recent imaging was 6 years ago. Updated MRI imaging evidence of a surgical lesion is required prior to surgical intervention. Therefore, the surgical request is not medically necessary.

Assistant Surgeon: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Centers for Medicare and Medicaid services, Physician Fee Schedule.

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

Abduction pillow brace purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

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

Micro cool unit purchase.: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy.

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

Interferential current unit with supplies purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

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

TENS unit with supplies rental x 1 month: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

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

Home exercise kit purchase for Right Shoulder.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Exercises.

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

Motorized compression pump with stocking 31 day rental.: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Venous Thrombosis.

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

Transportation to and from Surgery.: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79-80.

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

