

Case Number:	CM15-0001240		
Date Assigned:	01/12/2015	Date of Injury:	01/07/2008
Decision Date:	03/18/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/05/2015

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: New York
Certification(s)/Specialty: Neurological 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 67 year old male, who sustained an industrial injury on January 7, 2008. He has reported an injury to the left shoulder. The diagnoses have included biceps tenodesis, adhesive capsulitis and shoulder impingement. Treatment to date has included shoulder surgery, cortisone injection and pain medication. Currently, the injured worker complains continued left shoulder pain. He had surgery on 9/1/2008 for SAD and for biceps tenodesis and subsequent surgery on 3/9/2009 for an adhesive capsulitis. An examination of the injured worker revealed shoulder impingement and a possible adhesive capsulitis. A previous trial of cortisone injection did not provide improvement to the injured worker. On December 18, 2014 Utilization Review non-certified a request for acromioplasty in that there was no documentation to support that an aggressive course of conservative care had been tried. The request for post-operative physical therapy x 12, Keflex, Zofran and Vitamin C was noncertified in that the surgery was not recommended. The Official Disability Guidelines were cited. On January 5, 2015, the injured worker submitted an application for IMR for review of left shoulder arthroscopy, physical therapy x 12, Keflex, Zofran and Vitamin C.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery, Acromioplasty and Rotator cuff repair

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

Decision rationale: Diagnostic shoulder arthroscopy under ODG guidelines would be indicated if imaging were inconclusive in the patient with acute pain. Documentation does not state that this is the case. Under the guidelines arthroscopy would be indicated in the patient with functional limitations despite conservative care. According to the PR2 on 12/06/2014 the injured worker could forward elevate 120 degrees, passively elevate 125 and externally rotate 40 degrees. Thus the functional limitations are not substantial and the worker has only received one steroid injection. Guidelines allow for two more in this series. Thus conservative care has not been exhausted. Lastly, arthroscopy can be considered in the presence of rotator cuff tears. Documentation provides no evidence of this on studies.

Physical Therapy x 12 sessions: 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 (Unspecified dosage & quantity): 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 (Unspecified Dosage & quantity): 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(Unspecified Dosage & quantity): 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.