

Case Number:	CM15-0130012		
Date Assigned:	07/17/2015	Date of Injury:	06/25/2014
Decision Date:	08/14/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	07/06/2015

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: California, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic 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 48 year old male who sustained an industrial injury on 06/25/2014. The injured worker was diagnosed with left shoulder impingement syndrome and lumbar strain. Treatment to date has included diagnostic testing with recent Electromyography (EMG)/Nerve Conduction Velocity (NCV) studies in March 2015, L5-S1 epidural steroid injection, chiropractic therapy, acupuncture therapy, physical therapy, lumbar spine trigger point injections, localized intense neurostimulation (LINT) procedure and medications. According to the treating physician's progress report on May 19, 2015, the injured worker continues to experience bilateral shoulder pain, left side worse than the right and low back pain radiating to both thighs. Range of motion documented shoulder flexion/extension 180/50 degrees bilaterally, shoulder abduction/adduction at 180/50 degrees bilaterally, shoulder external and internal rotation at 90/90 degrees bilaterally, elbows within normal limits, wrist deviation radial/ulnar at 20/30 degrees bilaterally and fingers with full range of motion. Motor strength was documented at 5/5 from shoulder abduction to finger abduction. Sensation in all dermatomes and upper extremity deep tendon reflexes were intact. The left shoulder was positive for Neer's sign. The lumbar spine demonstrated tenderness to palpation over the paraspinal muscles with flexion at 60/60 degrees, extension and bilateral bend at 25/25 degrees. There was no tenderness over the spinous process. Motor strength and deep tendon reflexes were within normal limits. Straight leg raise was negative bilaterally. Current medications were not documented. Treatment plan consists of the current request for left shoulder arthroscopy, pre-operative chemistry panel laboratory blood work, chest X-ray, Electrocardiogram (EKG), urinalysis, pre-operative clearance for herniated nucleus pulposus, and post-operative physical therapy for the left shoulder twice a week for 8 weeks.

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: 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) shoulder.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case, the exam notes from 5/19/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the request does not adhere to guideline recommendations and is not medically necessary.

Pre-op chemistry panel, CBC, PTT/INR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

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

Pre-operative clearance HNP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

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

Pre-operative urinalysis: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

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

Pre-operative chest x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

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

Post-operative physical therapy for the left shoulder (2 times per week for 8 weeks): Upheld

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

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

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