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| Case Number: | CM15-0141030 | | |
| Date Assigned: | 08/03/2015 | Date of Injury: | 10/19/2012 |
| Decision Date: | 09/30/2015 | UR Denial Date: | 06/22/2015 |
| Priority: | Standard | Application Received: | 07/20/2015 |

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 57 year old male, who sustained an industrial injury on October 19, 2012. He reported a cumulative trauma injury of the right shoulder. The injured worker was diagnosed as having left shoulder bursitis and rotator cuff tear. On January 16, 2014, X-rays of the left shoulder revealed acromioclavicular arthrosis and a subacromial spur. On February 3, 2014, an MRI of the left shoulder revealed a full-thickness tear of the supraspinatus with retraction and atrophy with downsloping acromium and acromioclavicular joint degenerative change widening at the acromioclavicular joint and fragmentation. There was split biceps tendon in the bicipital groove raises the question for partial longitudinal tear with subscapularis tendinosis and partial tear. Treatment to date has included psychotherapy, chiropractic therapy, steroid injection, work modifications, and medications including oral and topical analgesic, anti-epilepsy, antidepressant, and non-steroidal anti-inflammatory. Other noted dates of injury documented in the medical record include: March 29, 2008 and May 18, 2011. Comorbid diagnoses included history of hypertension, hypercholesterolemia, heart abnormality, and diabetes type 2. On May 26, 2015, the injured worker reported constant, stabbing pain and numbness that begins at the left elbow and radiates up to the left shoulder. He reported left hand numbness, left shoulder swelling, radiating pain into the shoulder blade, unbearable pain when sitting up, and limited range of motion due to pain. His pain was rated 9 out of 10. The left shoulder exam revealed decreased range of motion, moderate diffuse tenderness to palpation, pain with all range of motion, no instability, positive Hawkin's and Speed's testing, and normal neurological and vascular exams. His work status is restricted with lifting: 25 pounds single lift,

5 pounds repetitive, 0 pounds overhead of the left upper extremity. The treatment plan includes left shoulder rotator cuff repair, left shoulder arthroscopy with subacromial decompression distal clavicle resection; medicine consult and pre-op clearance; pre-op: chest X-ray, electrocardiogram, complete blood count, chemistry 7, and PT/PTT/INR; Post-op Medication: Percocet, Keflex, Ambien, and Zofran; sling; brace; crutches; ice therapy; 12 sessions of chiropractic therapy; and follow-up 16 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Rotator Cuff Repair, Left shoulder Arthroscopy with Subacromial Decompression Distal Clavicle Resection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 48, 106, 111, 115, and 116.

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. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. Fatty infiltration in any of the muscles of the rotator cuff lowers the success of the repair in any of the muscles (Goutallier, 2003). In this case there is significant retraction of the rotator cuff and the rotator cuff has high grade fat atrophy on the MRI. Based on this, the request is not medically necessary.

Medicine Consult- Pre-op Clearance: 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.

Pre-op Chest X-ray: 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.

Pre-op EKG: 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.

Pre-op Labs: CBC: 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.

Pre-op Labs: Chemo 7: 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.

Pre-op Labs: PT/PTT/INR: 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-op Medication: Percocet 5/325mg #120: 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-op Medication: Keflex 500mg #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.

Post-op Medication: Ambien 10mg #30: 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-op Medication: Zofran 4mg #30: 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.

Associated service: Sling: 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.

Associated service: Brace: 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.

Associated service: Crutches: 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.

Associated service: Ice Therapy x 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.