

Case Number:	CM15-0141837		
Date Assigned:	08/06/2015	Date of Injury:	05/16/2013
Decision Date:	10/08/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/21/2015

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
 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 54 year old male who sustained an industrial injury on 05-16-2013. Current diagnoses include left shoulder bursitis and impingement, and left shoulder acromioclavicular arthritis. Previous treatments included medications, chiropractic-physiotherapy, left shoulder cortisone injection, cervical fusion and hardware removal, physical therapy, and acupuncture. Previous diagnostic studies included left shoulder x-rays, left shoulder MRI dated 06-10-2015, cervical spine MRI dated 11-25-2014. Report dated 06-12-2015 noted that the injured worker presented with complaints that included left shoulder pain. It was noted the injured worker gradually developed left shoulder pain from working as a heavy equipment operator. The injured worker presented to discuss imaging results and to discuss shoulder surgery. Pain level was 7-9 out of 10 on a visual analog scale (VAS). The injured worker has increased his activity and exercises including weight lifting, and has returned to work. He noticed the increase in pain after returning to work. Current medications include tramadol and a hypertension med. Physical examination was positive for decreased range of motion in the left shoulder, tenderness to palpation, and Neer's and Hawkin's testing was positive. The treating physician felt that due to failure with non-operative therapies including physical therapy and NSAID's, recommendation for operative treatment is necessary. The treatment plan included requests for left shoulder arthroscopy with subacromial decompression and distal clavicle resection, pre-operative medical clearance, and associated pre and post-operative services including medications, post-operative physical therapy, and follow up in 6 weeks. Disputed treatments include left shoulder arthroscopy with subacromial decompression and distal clavicle

resection, pre-operative clearance- medicine consult, pre-op chest x-ray, pre-op EKG, pre-op labs, CBC, pre-op labs, Chem7, pre-op labs, PT-PTT-INR, post-op Percocet 10/325mg #90, post-op Keflex 500mg #12, post-op Ambien 10mg #30, post-op Zofran 4mg #30, and post-op physical therapy 2 x 6 for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy with subacromial decompression and distal clavicle resection:
Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Acromioplasty.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 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 that is not present in the submitted clinical information from 6/12/15. 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 note from 6/12/15 does not demonstrate evidence satisfying the above criteria. Therefore the determination is not medically necessary.

Pre-operative clearance- Medicine consult: 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, Chem7: 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 Percocet 10/325mg #90: 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 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 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 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.

Post-op physical therapy 2 x 6 for the left shoulder: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.