

Case Number:	CM15-0143541		
Date Assigned:	08/06/2015	Date of Injury:	11/24/2014
Decision Date:	09/30/2015	UR Denial Date:	07/21/2015
Priority:	Standard	Application Received:	07/23/2015

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, Oregon, Washington
 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 11-24-2014 resulting in injury to the left shoulder, left elbow and left knee from repetitive activities. Treatment provided to date has included: physical therapy; cortisone injections; medications; and conservative therapies and care. Recent diagnostic testing included: MRI of the left shoulder (2015) showing supraspinatus, infraspinatus mild insertional tendinosis, and acromioclavicular joint mild arthrosis. There were no noted comorbidities or other dates of injury noted. On 07-13-2015, physician progress report noted complaints of left shoulder pain. The pain was rated 7 out of 10 in severity, and symptoms were described as achy, dull, clicking, popping, tenderness, stiffness, and decreased range of motion. Additional complaints included left elbow symptoms and left knee symptoms. Current medications include Norflex. The physical exam revealed loss of glenohumeral glide in the left shoulder, subacromial tenderness in the left shoulder, restrictive range of motion (ROM)slightly decreased infraspinatus strength, positive cross over test, positive Hawkin's sign, positive impingement sign, positive O'Brien's test, positive Speed's sign, and positive supraspinatus test. The provider noted diagnoses of rotator cuff sprain and strain, lateral epicondylitis of the left elbow, and sprains and strains of the knee and leg. Plan of care includes left shoulder surgery and follow-up in 6 weeks. The injured worker's work status remained temporarily totally disabled. The request for authorization and IMR (independent medical review) includes: left shoulder subacromial decompression, distal clavicle resection and debridement surgery; associated service: physician assistant; pre-operative clearance; post-operative medications: Norco #60 and Toradol #20; associated surgical services: continuous passive motion machine for 14 days, Polar Care (purchase), and sling with DVT prevention compression sleeves; and 12 sessions of post-operative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder SAD/DCR/Debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation, Shoulder Procedure Summary Online Version last updated 5/4/15.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

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 7/13/15. 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 7/13/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore, the determination is not medically necessary.

Associated service: PA assistant: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Preoperative Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Norco #60 (dosage unspecified):
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Toradol #20 (dosage unspecified): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated service: CPM x 14 days:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated service: Polar Care (purchase):
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated service: Sling/DVT prevention compression sleeves:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Postoperative Physical Therapy QTY 12: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.