MAXIMUS Federal Services

Case Number:	CM15-0187006		
Date Assigned:	09/30/2015	Date of Injury:	03/24/2014
Decision Date:	12/10/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/23/2015

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
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(n) 52 year old female, who sustained an industrial injury on 3-24-14. The injured worker was diagnosed as having impingement syndrome of the right shoulder and epicondylitis at the elbow with MRI showing a partial tear of the medial collateral ligament. Medical records (3-6-15 through 7-17-15) indicated the injured worker is unable to do her job due to pain. The physical exam (6-16-15 through 7-17-15) revealed decreasing right shoulder abduction from 165 to 140 degrees and a positive impingement sign. Treatment to date has included physical therapy x 8 sessions in 2014, a hot and cold wrap, a right shoulder MRI on 4-1-15 showing subacromial-subdeltoid bursitis, Motrin and Tramadol. As of the PR2 dated 8-18-15, the injured worker reports pain in the right shoulder, right elbow and right wrist and hand. Objective findings include right shoulder abduction is 130 degrees and extension is 25 degrees, a positive impingement sign and O'Brien test and tenderness along the posterior capsule. The treating physician requested a right shoulder arthroscopy decompression, an evaluation of the labrum and the biceps, a modified Mumford procedure, a pre-op H and P, a pre-op CBC, a pre-op EKG, a pre-op chest x-ray, an immobilizer, Gabapentin 600mg #180, Ondansetron 8mg #20 and pre-op clearance. On 8-18-15 the treating physician requested a Utilization Review for a right shoulder arthroscopy decompression, an evaluation of the labrum and the biceps, a modified Mumford procedure, a pre-op H and P, a pre-op CBC, a pre-op EKG, a pre-op chest x-ray, an immobilizer, Gabapentin 600mg #180, Ondansetron 8mg #20 and pre-op clearance. The Utilization Review dated 8-26-15, non-certified the request for a right shoulder arthroscopy decompression, an evaluation of the labrum and the biceps, a modified Mumford procedure, a

pre-op H and P, a pre-op CBC, a pre-op EKG, a pre-op chest x-ray, an immobilizer, Gabapentin 600mg #180, Ondansetron 8mg #20 and pre-op clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy decompression QTY 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder, acromioplasty surgery.

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 8/18/15. 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 8/18/15 does not demonstrate evidence satisfying the above criteria. Therefore the determination is for not medically necessary.

Evaluation of the labrum and the biceps QTY 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation ODG shoulder, labral tear surgery.

Decision rationale: 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. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis.There is insufficient evidence from the exam note of 8/18/15 to warrant labral repair secondary to lack of physical examination findings, lack of documentation of conservative care or characterization of the type of labral tear. Therefore determination is for not medically necessary.

Modified mumford procedure QTY 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation ODG, Shoulder, Partial claviculectomy.

Decision rationale: Based upon the CA MTUS Shoulder Chapter, Pgs 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. The Official Disability Guidelines Shoulder section, Partial Claviculectomy, states surgery is indicated for post traumatic AC joint osteoarthritis and failure of 6 weeks of conservative care. In addition there should be pain over the AC joint objectively and/or improvement with anesthetic injection. Imaging should also demonstrate post traumatic or severe joint disease of the AC joint. In this case the exam note from 8/18/15 and the imaging findings from 4/1/15 do not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore the determination is for not medically necessary.

Pre-op H&P QTY 1: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain, Office visits.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-op CBC: Upheld

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

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, preoperative testing.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-op chest X-ray QTY 1: Upheld

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

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Immobilizer: Upheld

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

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Gabapentin 600mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and postherpetic neuralgia and is considered first line treatment for neuropathic pain. In this case, the exam note from 8/18/15 does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore medical necessity has not been established, and determination is for not medically necessary.

Ondansetron 8mg #20: Upheld

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

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of Zofran for postoperative use. According to the ODG, Pain Chapter, "Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use." In this case the exam note from 8/18/15 does not demonstrate evidence of nausea and vomiting or increased risk for postoperative issues. Therefore determination is for not medically necessary.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, preoperative testing.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.