

Case Number:	CM15-0188723		
Date Assigned:	09/30/2015	Date of Injury:	09/01/2012
Decision Date:	12/11/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/25/2015

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 52 year old with a date of injury on 09-01-2012. The injured worker is undergoing treatment for complete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic and acromioclavicular joint arthritis. A physician progress note dated 08-20-2015 documents the injured worker complains of continued constant right shoulder pain, with weakness, and no improvement after the last injection. Examination reveals healed right shoulder incisions. Abduction and forward flexion 150-degrees actively and 170 degrees passively. During the last 20 degrees of passive range of motion, there is crepitation and popping. There is moderate subacromial tenderness and slight acromioclavicular joint tenderness. The injured worker has continued pain, crepitation and popping in the right shoulder. The physician states "I suspect he has scar tissue and-or suture material that is impinging causing significant pain. It also appears the acromioclavicular joint could be a source of his pain. He has failed to respond to cortisone injections and extensive physical therapy after the surgery." Surgery was recommended-diagnostic arthroscopy to remove the suture material and perform resection arthroplasty of the distal clavicle. Treatment to date has included diagnostic studies, medications, injections, status post right rotator cuff repair on 02-27-2015, and extensive physical therapy. No recent diagnostic studies were found in documents presented for review. The Request for Authorization includes Naprosyn 500mg #60 time two refills, Post-Operative Physical Therapy Three Times a Week for Four Weeks for the Right Shoulder, Pre-Operative EKG, and Pre- Operative Lab to include Blood, Pre-Operative Lab to include Urine, and Video Arthroscopy with Debridement and Resection Arthroplasty for the Right Shoulder. On 08-27-

2015 Utilization Review non-certified the request for Post-Operative Physical Therapy Three Times a Week for Four Weeks for the Right Shoulder, Pre-Operative EKG, Pre-Operative Lab to include Blood, Pre-Operative Lab to include Urine, and Video Arthroscopy with Debridement and Resection Arthroplasty for the Right Shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Video Arthroscopy with Debridement and Resection Arthroplasty for the Right Shoulder:
Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Diagnostic shoulder arthroscopy, Mumford.

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

Decision rationale: Based upon the CA MTUS Shoulder Chapter, 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 Claviclectomy, states surgery is indicated for posttraumatic 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 imaging does not demonstrate significant osteoarthritis or clinical exam findings to warrant distal clavicle resection. Therefore, the request is not medically necessary.

Pre-Operative Lab to include Blood: 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-Operative Lab to include Urine: 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-Operative 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.

Post-Operative Physical Therapy Three Times a Week for Four Weeks for the Right 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.