

Case Number:	CM15-0021688		
Date Assigned:	02/11/2015	Date of Injury:	10/05/2013
Decision Date:	04/07/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	02/05/2015

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 22 year old male, who sustained an industrial injury reported on 10/5/2013. He has reported aching right shoulder, elbow, forearm, wrist and hand pain. The diagnoses were noted to have included: right shoulder tendinosis and peri-tendinitis; right shoulder impingement syndrome with acromioclavicular joint pain; right elbow strain; right forearm crush injury; right ulnar neuropraxia; and right wrist strain. Treatments to date have included consultations; diagnostic imaging studies; electromyogram and nerve conduction studies to the right upper extremity; approved physical therapy; activity modifications; right shoulder injection therapy (7/2014); shoulder sling; and medication management. The work status classification for this injured worker (IW) was noted to be able to work with restrictions to not use the right arm and hand, but was not working. Exam note 10/24/14 demonstrates right shoulder pain. Exam demonstrates range of motion reveals active abduction at 165 degrees, adduction and extension at 40 degrees, impingement sign was noted to be positive. On 1/7/2015, Utilization Review (UR) non-certified, for medical necessity, the request, made on 1/2/2015, for: right shoulder arthroscopic subacromial decompression & Mumford procedure to cure the effects of the injury; motorized hot/cold unit for 7 days to reduce pain, edema and swelling, and to relax spasms; pro-sling with abduction pillow to stabilize and protect the joint; Sprix 15.75mg nasal spray for post-operative pain; and pre-operative clearance. The American College of Occupational and Environmental Medicine Guidelines, shoulder complaints, Impingement Syndrome, Surgery for impingement syndrome, Acromioplasty, partial claviclectomy (Mumford procedure) - indications for surgery, opioids; the Medical Treatment Utilization

Schedule, post-surgical treatment guidelines, shoulder, impingement syndrome, abduction pillow; and the Official Disability Guidelines, shoulder, continuous flow cryotherapy, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic subacromial decompression & Mumford procedure: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 10/24/14. 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 10/24/14 does not demonstrate evidence satisfying all of the above criteria. Therefore the determination is for non-certification.

Motorized hot and cold unit for 7 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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.

Pro sling with abduction pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

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.

Sprix 15.75mg nasal spray: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines, NSAIDs, pages 67-73, non-steroidal anti-inflammatories should be used at the lowest dose for the shortest period of time. Sprix is a nasal spray with non steroidal anti-inflammatory medication. The exam note from 10/24/14 does not indicate for what inflammatory condition is requiring treatment to warrant Sprix nasal spray. In addition there is no rationale why an oral medication is contraindicated. Therefore the determination is for non-certification.

Pre-Operative clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.guideline.gov.

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.