

Case Number:	CM15-0032752		
Date Assigned:	03/26/2015	Date of Injury:	09/23/2013
Decision Date:	05/12/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	02/23/2015

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, Sports Medicine

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 48-year-old female who reported an injury on 09/23/2013 due to repetitive movements. On 03/15/2015, she presented for an evaluation of her left shoulder and right elbow. She reported 7/10 pain in the left shoulder that would go down to a 6/10 pain after taking Norco. She continued to have difficulty with range of motion and reported that she could not raise her arm above shoulder height. She also had difficulty sleeping at night secondary to pain and noted the pain to be primarily over the insertion of the biceps and radiated over the top of the shoulder. Her medications included Trazodone 100 mg at bedtime, Lisinopril, Prozac, and Norco 10/325 mg 4 tablets a day. An examination of the left shoulder showed no swelling, deformity, or effusion. Active range of motion was documented as flexion to 110 degrees, extension to 60 degrees, abduction to 90 degrees, ER to 45 degrees, and IR to 70 degrees with ER at a 90 degree angle at 90 degrees. The joint was stable and tracked well with range of motion and there was no instability with manipulation. There was tenderness to palpation over the AC joint and biceps tendon and pain with range of motion. She had positive Neer's, Hawkins, and O'Brien's tests and strength was a 5/5 throughout. Sensation was normal and deep tendon reflexes were a 2+. It was noted that she had failed NSAIDs, physical therapy, and a steroid injection. An unofficial MRI of the left shoulder was performed on 11/19/2013 and showed a high grade tear within the long head of the biceps tendon at the level of the bicipital groove, mild to moderate acromioclavicular arthritis with moderate marrow edema surrounding the edema to overuse, and minimal bursal side fraying. She was diagnosed with left shoulder biceps tear, left shoulder tendinosis, and left shoulder AC joint arthrosis. The treatment plan was

for the injured worker to undergo a shoulder arthroscopy with subacromial decompression, distal clavicle resection, and open biceps tenodesis.

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, Distal Clavicle Resection, and Open Biceps Tenodesis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): s 209, 211, and 214. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Surgery for impingement syndrome, Indications for Surgery, Acromioplasty.

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

Decision rationale: The California ACOEM Guidelines indicate that a referral for a surgical consultation may be indicated for those who have red flags of a serious condition, activity limitations for more than 4 months, failure to increase range of motion and strength with exercise programs, and who have clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. It is also stated that surgery for biceps conditions is rarely indicated unless for cosmetic reasons as biceps injuries almost always improve with conservative therapies. The documentation submitted for review indicates that the injured worker has failed nonoperative treatment and continues to be symptomatic. However, no official imaging studies were provided for review to validate that the injured worker has deficits in the left shoulder that would support the requested surgical procedures. Also, no clear rationale was provided for the medical necessity of an open biceps tenodesis when an arthroscopic surgery is being requested. In addition, the request for a biceps tenodesis would not be supported as it is stated that these injuries can almost always be managed conservatively. Given the lack of imaging studies and lack of documentation to support all of the surgical procedures being requested, the request in its entirety would not be supported. As such, the request is not medically necessary.

Medicine Consult Pre-Operative Clearance: 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 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-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.

Pre-Operative Labs (CBC, Chem 7, 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.

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.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Zolpidem.

Decision rationale: According to the Official Disability Guidelines, Ambien is recommended for the short term treatment of insomnia for no longer than 7 to 10 days. The documentation

provided indicates that the injured worker had been having trouble sleeping due to pain. However, there is no indication that she had a diagnosis of insomnia that would support the request for Ambien. Also, further clarification is needed regarding how long she has been using this medication as it is only recommended for the short term treatment of 7 to 10 days. Furthermore, the frequency of the medication was not stated within the request and a quantity of 30 would not be supported as this medication is only recommended for 7 to 10 days. Therefore, the request is not supported. As such, the request is not medically necessary.

Purchase of DME Sling: 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.

Ice Therapy Cold Compression Therapy x 3 Weeks: Upheld

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

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 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Follow-Up S/P Surgery with General Orthopedic: 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.

Percocet 10/325mg #90: 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 On-Going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines indicate that an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects be performed during opioid therapy. The documentation provided indicates that the injured worker had already been taking Norco for pain relief. However, no official urine drug screens or CURES reports were provided for review to validate her compliance with the medication regimen and support the request for Percocet. Also, the frequency of this medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Antiemetics.

Decision rationale: The Official Disability Guidelines indicate that antiemetics are not supported for the treatment of stomach upset due to opiate therapy. The documentation provided does not state a clear rationale for the medical necessity of Zofran. It was noted within the documentation that she was using this medication for nausea. However, the documentation provided does not show that she had any subjective complaints regarding nausea due to her medication use to support the requested medication. Also, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.