

Case Number:	CM15-0035012		
Date Assigned:	03/03/2015	Date of Injury:	08/22/2011
Decision Date:	05/01/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/24/2015

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 57-year-old male who reported an injury on 08/22/2011. The mechanism of injury was not specifically stated. The current diagnosis is impingement with a degenerative labral tear and supraspinatus tendinosis of the right shoulder. The injured worker presented on 11/05/2014 for a follow-up evaluation regarding right shoulder pain. The injured worker reported ongoing right shoulder pain with any overhead activity. The injured worker was utilizing ibuprofen 800 mg, Percocet 10/325 mg, and Norco 10/325 mg. It was noted that the injured worker was status post right arthroscopic subacromial decompression on an unknown date. Upon examination, there was tenderness to palpation over the acromioclavicular joint. The provider indicated that the injured worker was a surgical candidate for a right shoulder arthroscopy with labral debridement and subacromial decompression. There was no Request for Authorization Form submitted for review. An official MRI of the right shoulder completed on 08/28/2014 was submitted, and revealed moderate supraspinatus and infraspinatus tendinosis without a full thickness tear; increased amount of fluid within the sheath of the long head biceps tendon, suggestive of tenosynovitis; thickening of the axillary pouch; and moderate degenerative/hypertrophic changes in the AC joint with capsular hypertrophy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy labral debridement and arthroscopic subacromial decompression (General A): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. In this case, there was no documentation of a recent exhaustion of conservative management to include a subacromial injection. The injured worker has been previously treated with a right shoulder arthroscopic subacromial decompression. In the absence of an exhaustion of recent conservative management, an additional surgical procedure would not be supported. Given the above, the request is not medically necessary.

CBC: 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.

Electrolyte Panel: 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.

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.

Chest X-rays: 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 , quantity 12 session: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 9.

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.

Shoulder 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.

Ultracet 375mg (Unknown quantity): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94 and 113.

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.