

Case Number:	CM15-0036469		
Date Assigned:	03/05/2015	Date of Injury:	06/17/2014
Decision Date:	04/16/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/26/2015

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 52-year-old male, who sustained an industrial injury on 06/17/2014. The diagnoses have included persistent left shoulder impingement syndrome. Noted treatments to date have included physical therapy, steroid injections, and medications. Diagnostics to date have included a prior MRI, which documented tendinosis of the supraspinatus per progress note. In the same progress note dated 12/30/2014, the injured worker presented with left shoulder complaints. The treating physician reported impingement signs and external rotation and abduction is mildly positive and internal rotation and adduction is mildly positive with mild crepitus noted. Utilization Review determination on 02/04/2015 non-certified the request for One (1) Outpatient Arthroscopy/Bursectomy, Acromioplasty of the Left Shoulder, Postoperative Physical Therapy to the left shoulder two (2) times a week for six (6) weeks, Vicodin 5/500mg #30, and Keflex 250mg #16 citing National Institutes of Health, Medical Treatment Utilization Schedule Guidelines, and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

One outpatient arthroscopy/bursectomy, acromioplasty of the left shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 12/30/14. 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 12/30/14 does not demonstrate evidence satisfying the above criteria. Therefore, the determination is for non-certification.

Post operative physical therapy to the left shoulder 2x6: 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.

Vicodin 5/500mg #30: 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 Opioids Page(s): 80.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 12/30/14. Therefore, the determination is for non-certification.

Keflex 250mg #16: 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 Stulberg DL, Penrod MA, Blatny RA. Common bacterial skin infections. Am FamPhysician. 2002 Jul 1; 66(1):119-24.

Decision rationale: CA MTUS/ACOEM and ODG are silent on the issue of Keflex. An alternative guideline was utilized. According to the American Family Physician Journal, 2002 July 1; 66 (1): 119-125, titled "Common Bacterial Skin Infections", Keflex is often the drug of choice for skin wounds and skin infections. It was found from a review of the exam note of 12/30/14 demonstrates no evidence of a wound infection to warrant antibiotic prophylaxis. The request for Keflex is therefore not medically necessary and appropriate.