

Case Number:	CM15-0075703		
Date Assigned:	05/04/2015	Date of Injury:	11/19/2008
Decision Date:	08/04/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	04/21/2015

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 November 19, 2008. The injured worker was diagnosed as having right shoulder recurrent impingement with partial thickness rotator cuff tear and glenoid labral tear and right elbow osteoarthritis with fibrosed biceps insertion. Treatment to date has included physical therapy, TENS, cortisone injections, right shoulder surgery, MRIs, and medication. Currently, the injured worker complains of severe right shoulder pain with limited range of motion (ROM) and right elbow pain. The Primary Treating Physician's report dated March 19, 2015, noted a right elbow MRI from February 17, 2015, was noted to show postsurgical changes with evidence of prior repair of the biceps tendon insertion, with the tendon thin, atretic, with scarring and fibrosis but unchanged, with early osteoarthritis of the elbow and lateral epicondyle. A MRI of the right shoulder from February 17, 2015, was noted to show bursitis and fraying of the supraspinatus, particularly near the greater tuberosity, which was stable, with continued synovitis, increased glenohumeral osteoarthritis, and a tear of the anterior and inferior labrum. Upper extremity examination was noted to show positive impingement signs in the right shoulder and a proximal contracture of the long head of the right biceps with multiple incisions about the right elbow, with retraction of the biceps proximally, lacking 30 degrees of extension of the elbow and 10 degrees of flexion. The treatment plan was noted to include a recommendation for arthroscopic subacromial decompression, as the injured worker wished to proceed with additional more aggressive management of the right shoulder. Prescriptions were provided for Tramadol and Anaprox.

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: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Indications for Surgery - Acromioplasty, Rotator Cuff Repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation ODG shoulder section, 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 3/19/15. 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 3/19/15 does not demonstrate evidence satisfying the above criteria. Therefore, the request is not medically necessary.

Pre-Operative Labs: 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, Low Back, Preoperative testing.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing.

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

Pre-Operative History and Physical: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Office Visits.

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

Post-Operative Physical Therapy 3 x 4: 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.

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-88.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

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

Tramadol 50mg BID as needed #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 93-94.

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

Keflex 500mg #28: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ANN SURG 2008; 247: 918-926, Antibiotics.

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 Fam Physician. 2002 Jul 1; 66(1): 119-24.

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