

Case Number:	CM15-0084711		
Date Assigned:	05/07/2015	Date of Injury:	12/23/2008
Decision Date:	08/04/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/04/2015

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 (IW) is a 42-year-old female who sustained an industrial injury on 12/23/2008. Diagnoses include symptomatic right shoulder impingement and inflammation. Treatment to date has included NSAID and opioid medications, physical therapy, steroid injections and surgery to the left shoulder x two. According to the progress notes dated 1/20/15, the IW reported problems with the right shoulder due to compensation for the left shoulder, which has had two surgeries. The notes stated there had been no physical therapy or injections for the right shoulder; a cortisone injection was given that day. An MRI from 11/20/14 showed tendinosis of the rotator cuff with possible calcific tendinitis and a small intramedullary lesion that may represent an interosseous lipoma or hemangioma. On examination, there was mild tenderness to the acromioclavicular joint and a positive impingement test. X-ray of the right shoulder was noted to show mild arthritic changes of the subacromial space. The IW subsequently underwent physical therapy; however, this and the steroid injection to the right shoulder did not provide satisfactory relief. A request was made for surgery and associated services: right shoulder possible labral repair, possible rotator cuff repair, subacromial decompression and debridement; medication: Keflex 500mg, #12, Zofran 4mg, #10, Ibuprofen 600mg, #90, Colace 100mg, #10, Norco 7.5/325mg, #50 and Vitamin C 500mg, #60; and post-operative physical therapy twice weekly for eight weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder possible labral repair, possible rotator cuff repair, subacromial decompression debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Shoulder Procedure Summary Online Version.

MAXIMUS 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) Shoulder, labral tear surgery.

Decision rationale: CA MTUS/ACOEM Shoulder Chapter, pages 209 and 210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. There is insufficient evidence from the exam note of 1/20/15 to warrant labral repair secondary to lack of physical examination findings, lack of documentation of conservative care or characterization of the type of labral tear. Therefore the request is not 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.

Zofran 4mg #10: 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, Ondansetron.

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

Ibuprofen 600mg #90: 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.

Colace 100mg #10: 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, Opioid Induced constipation treatment.

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

Norco 7.5/325mg #50: 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.

Vitamin C 500mg #60: 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-op Physical Therapy 2x/8weeks: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.