

Case Number:	CM14-0130543		
Date Assigned:	09/05/2014	Date of Injury:	01/26/1998
Decision Date:	09/25/2014	UR Denial Date:	08/11/2014
Priority:	Standard	Application Received:	08/15/2014

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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 56-year-old male sustained an industrial injury on 1/26/98. The mechanism of injury was not documented. The patient is status post L2/3 through L5/S1 lumbar interbody fusion and left shoulder arthroscopy in 2000. He did well following the left shoulder surgery until mid-2013. He reported that he lifted a heavy bag of dog food and felt a rip in his shoulder and a defect in the arm. Left shoulder x-rays on 3/20/14 showed a type II acromion, cystic changes at the distal end of the clavicle, loss of glenohumeral cartilage to 2 mm, and ring osteophyte. The 7/23/14 treating physician report cited continued left shoulder pain associated with bursitis and glenohumeral degenerative joint disease that was worsening. Subacromial/acromioclavicular (AC) injections provided temporary relief but were wearing off. Left shoulder exam documented no atrophy, AC joint and subacromial space tenderness, positive cross arm test, and crepitation in the subacromial area. Range of motion documented forward flexion 90, adduction 60, and external rotation 25 degrees, with internal rotation to the sacroiliac joint. Upper extremity strength and reflexes were normal. There were positive impingement tests with no findings of instability. The diagnosis was left shoulder osteoarthritis, biceps rupture, subacromial bursitis, and AC joint arthritis. The patient had failed oral medications, injections, therapy and time. Authorization was requested for subacromial decompression and acromioclavicular excision. The 8/11/14 utilization review denied the left shoulder surgeries and associated requests as there was no imaging evidence of impingement as required by guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder scope with AC joint excision, subacromial decompression and repair of internal derangement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (acute & chronic), Indications for surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings (conventional x-rays and Gadolinium MRI, ultrasound, or arthrogram) showing positive evidence of impingement are required. Guideline criteria have not been met. There is no evidence of MRI, ultrasound or arthrogram findings showing positive evidence of impingement as typically required by guidelines. Therefore, this request is not medically necessary.

12 post-op physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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

Cold therapy unit with pad: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (acute & chronic), Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy.

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

1 Smartsling purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205,213.

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

Vicoprofen 7.5mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212 and Table 9-6,Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use. Opioids, specific drug list Page(s): 76-80,92.

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

Norco 5mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212 and Table 9-6,Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use. Opioids, specific drug list Page(s): 76-80,91.

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

Zofran 8mg #15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (chronic), Antiemetics (for opioid nausea), Ondansetron (Zofran).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice guidelines for postanesthetic care: an updated report by the American Society of Anesthesiologists Task Force on Postanesthetic Care. Anesthesiology. 2013 Feb;118(2):291-307.

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