MAXIMUS Federal Services

Case Number:	CM14-0216312		
Date Assigned:	01/06/2015	Date of Injury:	02/19/2012
Decision Date:	03/17/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/24/2014

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. 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: New York
Certification(s)/Specialty: Neurological 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:

This 29 year old male correctional officer had a date of injury of 02/19/2012 from an assault by an inmate resulting in ongoing left shoulder pain that had not improved with activity change, non-steroidal anti-inflammatory medications, acupuncture, plasma rich platelet injections, shock wave and physical therapy. The PR2 of 07/13/2013 noted complaints of shoulder pain with popping and clicking, no improvement with physical therapy but medications were giving good relief. Exam showed tenderness on the posterior aspect of the shoulder with range of motion. Diagnosis at that time was subacomial bursitis and depression. A MRI arthrogram of 12/23/2013 showed a posterior labrum tear, down sloping acromion and an osteochondral lesion along the humeral head. Supraspinatus and infraspinatus tendonosis was described. PR2 of 01/28/2014 noted EMG was normal and nerve conduction studies showed a carpal tunnel syndrome. PR2 of 07/16/2014 noted exam showed no atrophy but pain with motion over the medial aspect of the scapula. Shoulder abduction of 0-80. On 9/06/2014 he was describing spasms, clicking, popping and pain exacerbating by prolonged overhead reaching. His flexion was noted to be 180/180, extension 50/50, adduction 180/180 external rotation at 90/90 and internal rotation at 80/80. Orthopedic consultation was requested for rotator cuff tear and left shoulder internal derangement.At the time of the comprehensive orthopedic evaluation on 10/23/2014 he had positive Neer, Hawkins, and cross body adduction tests. His active range of motion (ROM) was 80/45 and back pocket limited by pain. He had a full ROM when supine, 4/5 strength on external rotation, negative bear hugger, belly press, Speed and Yergason's tests. The Utilization Review on 11/24/14 denied the requests for Arthroscopy with subacromial decompression,

possible rotator cuff repair, arthroscopy with debridement, arthroscopy with arthroplasty, SLAP (Superior labral tear from anterior to posterior) repair, with anesthesia and preoperative clearance, post-operative physical therapy, CPM and rental of cold unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopy subacromial decompression with possible rotator cuff repair QTY #1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

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

Decision rationale: California MTUS Guidelines require for surgical consideration on the shoulder that the injured worker have clear clinical and imaging evidence of the presence of a lesion that has been shown to benefit from surgery. The clinical exam and the imaging of the imaging worker's shoulder does not validate this criteria. SLAP (Superior labral tears anterior to posterior) in a high percentage of cases will respond to conservative measures. MRI scan does not characterize this worker's posterior labrum tear. No thickening of muscle tendons or anatomy suggests an impingement syndrome. Criteria for arthroplasty, debridement , decompression and rotator cuff repair are not met.

Arthroscopy with debridement QTY#1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

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

Decision rationale: California MTUS Guidelines require for surgical consideration on the shoulder that the injured worker have clear clinical and imaging evidence of the presence of a lesion that has been shown to benefit from surgery. The clinical exam and the imaging of the imaging worker's shoulder does not validate this criteria. SLAP (Superior labral tears anterior to posterior) in a high percentage of cases will respond to conservative measures. MRI scan does not characterize this worker's posterior labrum tear. No thickening of muscle tendons or anatomy suggests an impingement syndrome. Criteria for arthroplasty, debridement, decompression and rotator cuff repair are not met.

Arthroscopic AC arthroplasty QTY#1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

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

Decision rationale: California MTUS Guidelines require for surgical consideration on the shoulder that the injured worker have clear clinical and imaging evidence of the presence of a lesion that has been shown to benefit from surgery. The clinical exam and the imaging of the imaging worker's shoulder does not validate this criteria. SLAP (Superior labral tears anterior to posterior) in a high percentage of cases will respond to conservative measures. MRI scan does not characterize this worker's posterior labrum tear. No thickening of muscle tendons or anatomy suggests an impingement syndrome. Criteria for arthroplasty, debridement, decompression and rotator cuff repair are not met.

superior labrum, anterior to posterior (SLAP) repair: 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)

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

Decision rationale: California MTUS Guidelines require for surgical consideration on the shoulder that the injured worker have clear clinical and imaging evidence of the presence of a lesion that has been shown to benefit from surgery. The clinical exam and the imaging of the imaging worker's shoulder does not validate this criteria. SLAP (Superior labral tears anterior to posterior) in a high percentage of cases will respond to conservative measures. MRI scan does not characterize this worker's posterior labrum tear. No thickening of muscle tendons or anatomy suggests an impingement syndrome. Criteria for arthroplasty, debridement, decompression and rotator cuff repair are not met.

Under general anesthesia QTY #1: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested surgery is not necessary, anesthesia is not needed.

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

Pre operative clearance QTY#1: 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)- low back chapter, preoperative testing

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested surgery is not necessary, pre-operative clearance is not needed.

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

Electrocardiogram (EKG) QTY #1: 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)- low back chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested surgery is not necessary, EKG is not needed.

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

Complete Blood Count QTY #1: 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)- low back chapter, preoperative lab testing

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested surgery is not necessary, complete blood count is not needed.

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

Electrolytes QTY #1: 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)- low back chapter, preoperative lab testing

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested surgery is not necessary, electrolytes are not needed.

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

Urine Drug screen QTY #1: 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)- low back chapter, preoperative lab testing

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested surgery is not necessary, urine drug screen is not needed.

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

Prothrombin Time/ Partial Thromboplastin Time (PT/PTT) QTY #1: 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)- low back chapter, preoperative lab testing

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested surgery is not necessary, prothrombin/partial thromboplastin time are not needed.

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

CPM (in days) QTY #21: 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 chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested surgery is not necessary, CPM is not needed.

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

cold therapy unit (in days) QTY #21: 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 chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested surgery is not necessary, cold therapy unit is not needed.

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

post operative physical therapy QTY #12: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Since requested surgery is not necessary, post operative physical therapy is not needed.

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