

Case Number:	CM15-0123563		
Date Assigned:	07/08/2015	Date of Injury:	06/23/1992
Decision Date:	09/17/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	06/26/2015

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, Oregon, Washington
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 77 year old male who sustained an industrial injury on 06/23/1992. The mechanism of injury and initial report of injury are not found in the records reviewed. The injured worker was diagnosed as having bilateral shoulder pain. Treatment to date has included a left shoulder arthroplasty with a revision several months later for loosening of the humeral head, a biceps injection with good relief, and a subacromial injection on the left. At this time, X-rays show severe osteoarthritis in the right shoulder and a painful arthroplasty on the left. Currently, the injured worker complains of right shoulder pain post painful left shoulder arthroplasty. The pain is isolated to the biceps tendon. A Left shoulder arthroscopy diagnostic with biceps tenodesis and subacromial decompression was discussed with the worker and he wishes to proceed. Requests for authorization were made for the following: 1. Left Shoulder Diagnostic Arthroscopy with Biceps Tenodesis and Subacromial Decompression Qty 1. 2. Post-Op Ultrasling for the Left Shoulder, 3. Associated Surgical Service: Percocet 10/325 MG Qty 30. 4. Associated Surgical Service: Ibuprofen 600MG Qty 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Diagnostic Arthroscopy with Biceps Tenodesis and Subacromial Decompression 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), Indications for Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209 and 210.

Decision rationale: According to the 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. 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 5/29/15. 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 5/29/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is not medically necessary.

Post-Op Ultrasling for The Left Shoulder: 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.

Associated Surgical Service: Percocet 10/325 MG Qty 30: 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.

Associated Surgical Service: Ibuprofen 600 MG Qty 30: 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 PT for Left Shoulder Qty 16: 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.