

Case Number:	CM15-0170477		
Date Assigned:	09/17/2015	Date of Injury:	11/06/2010
Decision Date:	11/06/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/29/2015

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, Indiana, Oregon
 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 50 year old female, who sustained an industrial injury on 11-6-10. The injured worker was diagnosed as having lumbar spinal stenosis. Treatment to date has included physical therapy; medications. Diagnostics studies included MRI right shoulder (7-22-15). Currently, the PR-2 notes dated 7-27-15 indicated the injured worker is in the office for a follow- up after the MRI of her right shoulder. The provider documents the injured worker had X-rays along with MRI's of the cervical spine (8025011) and of the right shoulder (8-31-11). A provider at that time reviewed the diagnostic studies and recommended a subacromial decompression and rotator cuff repair with possible labral repair. However, it was advised against the surgery until she had undertaken a neurological test to find the cause of the hand shaking which the provider documents proved "negative in a subsequent trip to Taiwan." He notes that physical therapy did not help, cortisone injections in 2012 helped eliminate the hand shaking. During 2012-2014 she had chiropractic and acupuncture therapy. She currently works part time in the same field but limits herself to half days due to fatigue. She is now seeking an orthopedic surgeon to address her shoulder. On physical examination of the right shoulder, the provider documents "right shoulder sits lower than the left, tenderness: lateral, range of motion: abduction: passive normal, active decreased; external rotation passive: normal, active decreased; internal rotation passive" normal, active normal. Strength: supraspinatus: normal, Infraspinatus: normal; Suprascapularis: normal; Deltoid: normal. Stability-Laxity: Anterior Apprehension: negative; relocation: negative; Anterior translation: negative; Posterior Translation: negative; O'Brien's: negative; Lift Off Test: negative; Hawkin's: negative; Cross Body: negative; Neer's: negative; Speed's: positive." A MRI of

the right shoulder without contrast is reported on 7-22-15 with an impression revealing: "1) Moderate supraspinatus and anterior infraspinatus tendinosis without tear. 2) Mild proximal extra-articular biceps tenosynovitis measuring 15mm superoinferior. 3) Mild synovitis of axillary pouch and mid rotator interval. 4) Mild AC joint arthrosis with mild joint hypertrophy. 5) The BLC and IGLLC are intact." The provider documents in his treatment plan "presents with biceps tenosynovitis of the [right] shoulder, and a bone spur of the [right] acromioclavicular joint." He reviews the MRI findings noting "tendon inflammation and the bone spur." He notes conversation with the injured worker and her husband indicating "previous treatment options such as manual therapy and cortisone injections have not helped to alleviate" the injured worker's "symptoms or improve her ROM." The injured worker has agreed to surgery on the right shoulder. A PR-2 noted dated 3-2-15 indicated similar documentation for medical and physical history for right shoulder pain and therapy. The MRI of the right shoulder was requested on this date. A Request for Authorization is dated 8-29-15. A Utilization Review letter is dated 8-5-15 and non-certification was for of 1) Right shoulder arthroscopic subacromial decompression and labral debridement; 2) Assistant surgeon x 2 units; 3) Pre-operative clearance, Physical; 4) Pre-operative EKG; 5) Pre-operative complete blood count (CBC); 6) Pre-operative chem 9; 7) Post-operative shoulder brace; 8) Post-operative cold therapy unit; 9) Post-operative physical therapy x 12 visits; 10) Post-operative Norco 10/325mg #50; 11) Post-operative Colace 100mg #50 and 12) Post-operative Zofran 9mg #20. Utilization Review denied the requested treatments for not meeting the CA MTUS, ACOEM and ODG Guidelines. The provider is requesting authorization of 1) Right shoulder arthroscopic subacromial decompression and labral debridement; 2) Assistant surgeon x 2 units; 3) Pre-operative clearance, Physical; 4) Pre-operative EKG; 5) Pre-operative complete blood count (CBC); 6) Pre-operative chem 9; 7) Post-operative shoulder brace; 8) Post-operative cold therapy unit; 9) Post-operative physical therapy x 12 visits; 10) Post-operative Norco 10/325mg #50; 11) Post-operative Colace 100mg #50 and 12) Post-operative Zofran 9mg #20.

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 and labral debridement: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

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

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 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. 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, there is no documentation of weak or absent abduction. The request is not medically necessary.

Associated surgical service: Assistant surgeon x 2 units: 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.

Pre-operative clearance, Physical: 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.

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 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.

Pre-operative complete blood count (CBC): 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.

Pre-operative chem 9: 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.

Post-operative shoulder brace: 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.

Post-operative cold therapy unit: 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.

Post-operative physical therapy x 12 visits: 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.

Post-operative Norco 10/325mg #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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-operative Colace 100mg #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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-operative Zofran 9mg #20: 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.