

Case Number:	CM13-0056351		
Date Assigned:	12/30/2013	Date of Injury:	01/14/2010
Decision Date:	05/21/2014	UR Denial Date:	11/11/2013
Priority:	Standard	Application Received:	11/22/2013

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 Orthopedic 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:

The claimant is a 53-year-old female who was injured in work related accident on 01/14/10 and underwent shoulder surgery consisting of a labral repair on November 31, 2011. The clinical records provided for review specific to the claimant's right shoulder included a recent MRI report dated 05/02/12 documenting postsurgical changes at the labrum with previous anchor from surgical repair. No indication of re-tearing was noted but rotator cuff tendinosis with mild bicipital tendinosis, and acromioclavicular joint arthrosis were seen. The progress report of October 23, 2013 documented ongoing shoulder complaints and noted that the claimant had failed conservative treatment and was awaiting a second surgery for distal clavicle resection, acromioplasty and rotator cuff repair. Physical examination findings on that date showed weakness with supraspinatus and infraspinatus testing at 4/5, tenderness to palpation over the acromioclavicular joint and restricted range of motion at endpoints of active flexion and extension. The previous report of September 11, 2013 documented that the claimant underwent an injection to the shoulder that gave temporary relief from the anesthetic portion of the injection but provided no long-term benefit. Additional conservative care included an injection performed at the acromioclavicular joint and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER DISTAL CLAVICLE RESECTION, ACROMIOPLASTY, POSSIBLE ROTATOR CUFF REPAIR: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Worker's Comp , 18th Edition, 2013 Updates: Shoulder Procedure .

Decision rationale: Based on CA MTUS ACOEM Guidelines and supported by the Official Disability Guidelines, the request for right shoulder distal clavicle resection, acromioplasty, possible rotator cuff repair is medically necessary. The claimant has failed conservative care including multiple injections and continues to be symptomatic with diminished motion, weakness and tenderness to the acromioclavicular joint on examination. The claimant's clinical picture including failure to improve with appropriate conservative measures would meet the ACOEM and ODG Guidelines for the proposed procedure. The request for Right shoulder distal clavicle resection, acromioplasty, possible rotator cuff repair is medically necessary.

PRE-OP LABS (CBC, COMP MET, EKG): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Edition, Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (Chapter 7 Independent Medical Examinations and Consultations, page 127. Hegmann K, Occupational Medicine Practice Guidelines, 2nd Ed (2008 Revision), page 503 and Official Disabilit

Decision rationale: The request for right shoulder distal clavicle resection, acromioplasty, possible rotator cuff repair is recommended as medically necessary. The request for preop testing for labs and EKG would also be as medically necessary given the need for the surgery which would require the claimant to undergo anesthesia. The request for Pre-op Labs are medically necessary.

PRE-OP CLEARANCE: Overturned

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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (Chapter 7 Independent Medical Examinations and Consultations, page 127.

Decision rationale: The request for right shoulder distal clavicle resection, acromioplasty, possible rotator cuff repair is as medically necessary. The ACOEM Guidelines would support the

role of preoperative medical clearance given the nature of the surgical process and need for anesthesia for the surgery. The request for Pre-Op Clearance is medically necessary.

POST-OP PHYSICAL THERAPY 2 TIMES PER WEEK FOR 6 WEEKS FOR THE RIGHT SHOULDER: Overturned

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 Postsurgical Treatment Guidelines.

Decision rationale: The request for right shoulder distal clavicle resection, acromioplasty, possible rotator cuff repair is as medically necessary. The CA MTUS Postsurgical Rehabilitative Guidelines would support the role of 12 sessions of physical therapy given the nature of the surgical process in question. The request for Post-Op Physical Therapy is medically necessary.

POST-OP PAIN MED PERCOCET 10/325MG, #80: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet, Page(s): 92.

Decision rationale: The request for right shoulder distal clavicle resection, acromioplasty, possible rotator cuff repair is medically necessary. The CA MTUS Chronic Pain Guidelines would also support the request for Percocet for postop management of the claimant's pain. The request for Post-Op Pain Med Percocet is medically necessary.

POST-OP NORCO 10/325MG, #80: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco, Opioids: Page(s): 91, 76-80.

Decision rationale: The request for right shoulder distal clavicle resection, acromioplasty, possible rotator cuff repair is medically necessary. The CA MTUS Chronic Pain Guidelines do not also support the request for Norco for postop management of the claimant's pain. There is a request for Percocet that has been recommended as medically necessary. The Chronic Pain Guidelines do not recommend prescribing the claimant two short acting narcotic analgesics for the recommended surgery for the right shoulder. A prescription for one analgesic would be reasonable. The prescription for the second analgesic Norco of similar purpose would not be supported. The request for Post-Op Norco 10/325mg is not medically necessary.

