

Case Number:	CM14-0004388		
Date Assigned:	02/05/2014	Date of Injury:	08/12/2009
Decision Date:	06/20/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	01/13/2014

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 59-year-old female housekeeper sustained an industrial injury on 6/12/09, with no specific mechanism of injury documented. The patient underwent a right arthroscopy and rotator cuff repair in 2010 and completed post-operative physical therapy. She is also status post right total knee replacement on 11/6/12. The 4/8/12 right shoulder MR arthrogram demonstrated a 1 cm tear of the rotator cuff with some mild to moderate atrophic changes of the supraspinatus tendon. There was no infraspinatus or subscapularis tendon tear. There was a tear of the superior labrum, with no tear of the attachment of the long head of the biceps. Records indicate that physical therapy for the shoulders was approved on 4/9/13, but there is no evidence that this care was provided. The 11/20/13 AME report cited complaints of bilateral shoulder pain, and decreased range of motion, greater on the left side. A cortisone injection was provided to the left shoulder in October which she stated helped the pain for about a week. The 12/4/13 treating physician report indicated the patient had continued right shoulder pain and achiness. Functional difficulty was reported with work at or above shoulder level and reaching behind her back. Physical exam findings documented right shoulder forward flexion and abduction of 155 degrees and significant weakness in external rotation and supraspinatus testing. The 12/19/13 utilization review denied the request for right shoulder surgery with associated post-operative physical therapy, durable medical equipment, and medications, as there was no documentation of recent adequate conservative treatment failure.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY, SAD, RTC REPAIR AND DEBRIDEMENT/ASSISTANT SURGEON, POST-OPERATIVE PHYSICAL THERAPY, 2 VISITS WEEKLY FOR 6 WEEKS, ICE MACHINE AND SLING: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, Chronic Pain Treatment Guidelines Page(s): 79-81. 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 Official Disability Guidelines (ODG), Shoulder

Decision rationale: Under consideration is a request for right shoulder arthroscopy, subacromial decompression, rotator cuff repair, and debridement with assistant surgeon, 12 post-operative physical therapy sessions, ice machine, and sling. The California MTUS guidelines do not provide recommendations for surgeries in chronic shoulder conditions. The Official Disability Guidelines for rotator cuff repair of partial thickness tears require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). Guidelines state that conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering arthroscopic decompression. Guideline criteria have not been met. There is no documentation of positive impingement signs or a positive diagnostic injection test for the right shoulder. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment has been tried and failed. Recent physical therapy directed towards gaining full range of motion is not documented. Therefore, the request for right shoulder arthroscopy, subacromial decompression, rotator cuff repair, and debridement is not medically necessary. Given that the surgical request is not medically necessary, the associated requests for assistant surgeon, 12 post-operative physical therapy sessions, ice machine, and sling are also not medically necessary.

OXYCODONE 20 MG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Opioids Page(s): 45,47,79-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Opioids.

Decision rationale: Under consideration is a request for Oxycodone 20 mg. The California MTUS indicate that short-acting opioids, such as Oxycodone, are an effective method in controlling chronic pain and often recommended for intermittent or breakthrough pain. Records indicate that this is a request for post-operative medication. Therefore, as the right shoulder arthroscopic surgery is not medically necessary, this request for post-operative Oxycodone 20 mg is also not medically necessary.

VICODIN 5/500 MG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines CHAPTER OPIOIDS, Page(s): 45,47,79-81. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, 91 Page(s): 91.

Decision rationale: Under consideration is a request for Vicodin 5/500 mg. The California Medical Treatment Utilization Schedule guidelines support the use of Vicodin for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Records indicate that this is a request for post-operative medication. Therefore, as the right shoulder arthroscopic surgery is not medically necessary, this request for post-operative Vicodin 5/500 mg is also not medically necessary.