

Case Number:	CM14-0011791		
Date Assigned:	02/21/2014	Date of Injury:	09/16/2002
Decision Date:	06/25/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	01/29/2014

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 Occupational Medicine 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:

Patient is a 70 year-old male with date of injury 09/16/2002. The medical record associated with the request for authorization, a primary treating physician's progress report, dated 12/02/2013, lists subjective complaints as profound weakness in his left upper extremity as a result of polio; such that his left wrist and hand are available only for somewhat of a stabilizer helping hand. Patient was authorized to undergo reverse total shoulder arthroplasty on 01/10/2014. Physician reports that the patient will be significantly incapacitated in his ability to perform most of the day-to-day post-operative necessities, such as perineal hygiene and using the bathroom for the first several weeks. After arthroscopic surgery, for the first three weeks, there is to be no internal range of motion and no positioning of the right upper extremity behind the level of the mid axillary line. Diagnosis: 1. Right shoulder arthroscopy, with chronic dislocation and increasing pain. 2. Status post revision of the left knee 3. Depression and anxiety 4. Post-polio syndrome with weakness in the upper extremities, left greater than right 5. Visual disturbance, non-industrial. There is no evidence in the medical records provided for review that the patient has been prescribed the following medications before the request for authorization on 12/02/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 WEEK POST OP PLACEMENT IN AN EXTENDED CARE FACILITY AT HEALTH SOUTH FACILITY IN TUSTIN: 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), Hospital Stay (LOS) Guidelines: Total Shoulder (ICD 81.80 - Total Shoulder Replacement

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

Decision rationale: The requested for authorization is for 4 weeks in a rehabilitation hospital. The patient has a severely paretic left upper extremity, and following surgery to his right shoulder he will be left with essentially no use of both upper extremities. The previous utilization review officer recommended 2 days in the rehabilitation hospital, with further days authorized as needed. The request for 4 weeks in the rehabilitation hospital seems excessive. I am certain that the patient will need more than 2 days, however. An independent medical reviewer has no latitude to modify a request, only to determine if the request is medically necessary. Under this constraint, the 4-week postoperative placement in an extended care facility at health south facility is not medically necessary.

UNKNOWN PRESCRIPTION OF NEURONTIN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19.

Decision rationale: The requested for authorization of Neurontin contains no number of capsules prescribed or directions for its use. The unknown prescription of Neurontin is not medically necessary.