

Case Number:	CM14-0046099		
Date Assigned:	08/06/2014	Date of Injury:	04/21/2000
Decision Date:	10/08/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/14/2014

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 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 54-year-old female who sustained an injury to her bilateral shoulders on April 21, 2000. The clinical records provide for review specific to shoulder complaints included the March 18, 2014, progress report noting ongoing shoulder discomfort for a current diagnosis of left shoulder impingement, status post two prior surgeries including decompression, distal clavicle excision, biceps tenotomy and a second surgery for rotator cuff repair. Objective findings on examination reveal restricted range of motion to 90 degrees of abduction, tenderness over the rotator cuff and acromioclavicular joint and negative liftoff testing. There were no formal reports of imaging studies provided for review. The treating provider documented that the claimant has failed conservative care and recommended a third operative procedure for the left shoulder for arthroscopic rotator cuff repair. The medical records did not document the specific conservative measures provided to the claimant. This review is for shoulder arthroscopy and rotator cuff repair, evaluation of subcapsularis, preoperative clearance, a twenty-one day rental of a polar care unit, Rejuveness, Zofran, Amoxicillin, Neurontin, and a shoulder immobilizer.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder Arthroscopy Rotator Cuff Repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder - Surgery for Rotator Cuff Repair

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

Decision rationale: Based on California ACOEM Guidelines, the request for shoulder arthroscopy and rotator cuff repair surgery cannot be recommended as medically necessary. ACOEM Guidelines recommend that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation. The medical records do not contain any imaging reports to determine recurrent rotator cuff pathology. It is documented that this claimant has already undergone a prior rotator cuff repair. Without formal documentation of claimant's postoperative imaging, the role of a revision procedure would not be supported as medically necessary.

Pre Operative Clearance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder - Surgery for Rotator Cuff Repair

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: (Second Edition, 2004), Chapter 7 Independent Medical Examinations and Consultations, page 127.

Decision rationale: The request for shoulder arthroscopy and rotator cuff repair is not recommended as medically necessary. Therefore, the request for preoperative medical clearance is also not medically necessary.

Polar Car, 21 Days Rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder - Surgery for Rotator Cuff Repair

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, 555-556.

Decision rationale: The request for shoulder arthroscopy and rotator cuff repair is not recommended as medically necessary. Therefore, the request for a Polar Care unit, 21 day rental is also not medically necessary.

Shoulder Immobilizer: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder - Surgery for Rotator Cuff Repair

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp , 18th Edition, 2013 Updates: shoulder procedure - Postoperative abduction pillow sling Recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for ar

Decision rationale: The request for shoulder arthroscopy and rotator cuff repair is not recommended as medically necessary. Therefore, the request for a shoulder immobilizer is also not medically necessary.

Rejuveness: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder - Surgery for Rotator Cuff Repair

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Cochrane Database Syst Rev. 2013 Sep 12;9:CD003826. doi: 10.1002/14651858.CD003826.pub3. Silicone gel sheeting for preventing and treating hypertrophic and keloid scars. O'Brien L1, Jones DJ. Abstract

Decision rationale: The request for shoulder arthroscopy and rotator cuff repair is not recommended as medically necessary. Therefore, the request for ReJuveness is also not medically necessary.

Amoxicillin 875 mg #20: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder - Surgery for Rotator Cuff Repair

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Prokuski L.Source University of Wisconsin Hospitals, Madison, WI 53792, USA. Abstract

Decision rationale: The request for shoulder arthroscopy and rotator cuff repair is not recommended as medically necessary. Therefore, the request for Amoxicillin is also not medically necessary.

Zofran 8 mg #20: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder - Surgery for Rotator Cuff Repair

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp , 18th Edition, 2013 Updates: pain procedure - Antiemetics (for opioid nausea)

Decision rationale: The request for shoulder arthroscopy and rotator cuff repair is not recommended as medically necessary. Therefore, the request for Zofran is also not medically necessary.

Neurontin 600 mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder - Surgery for Rotator Cuff Repair

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), Page(s): 18.

Decision rationale: The request for shoulder arthroscopy and rotator cuff repair is not recommended as medically necessary. Therefore, the request for Neurontin, a neuropathic agent in this case, is also not medically necessary. There is also no documentation of a diagnosis of neuropathic pain to support the need for Neurontin.

Evaluation of Subscapularis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder - Surgery for Rotator Cuff Repair

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

Decision rationale: The request for shoulder arthroscopy and rotator cuff repair is not recommended as medically necessary. Therefore, the request for subscapularis evaluation is also not recommended as medically necessary.