

Case Number:	CM14-0056054		
Date Assigned:	07/09/2014	Date of Injury:	12/09/2013
Decision Date:	09/22/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	04/25/2014

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 Physical Medicine & Rehabilitation, Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 57-year-old male who reported an injury on 12/09/2013. The mechanism of injury was a pulling injury. The injured worker had a diagnosis of right shoulder tendonitis and rotator cuff tear. Past treatment included medications and 6 physical therapy sessions. Diagnostic testing included x-rays and an MRI of the right shoulder dated 01/30/2014. No previous surgical history was provided. The injured worker complained of constant sharp right shoulder pain rated 6/10 at rest and 8/10 with activity. The injured worker also complained of numbness, depression, and insomnia. Physical exam findings on 03/06/2014 showed the injured worker had marked tenderness to palpation over the greater tuberosity in the area of the supraspinatus tendon, upper trapezius, levator, and acromioclavicular joint. The range of motion of the right shoulder demonstrated extension of 40 degrees active and passive, 70 degrees of active flexion, and 70 degrees of passive abduction and 45 degrees of active abduction. The injured worker had a positive Hawkins's impingement maneuver and a positive Neer's impingement sign. Medications included Ibuprofen, Hydrocodone, and Cylobenzaprine. The documentation indicated the injured worker had an allergy to Percocet, which caused the injured worker to develop a rash. The treatment plan included recommendations for right shoulder diagnostic arthroscopy with subacromial, decompression, repair of the rotator cuff and excision of the distal clavicle with a pre-operative clearance, Arc 2.0 abduction sling, if rotator cuff repair is performed, 24 sessions of post-operative physical therapy, post-operative Percocet, and a cold compression unit for 2 weeks. The cold compression unit and Percocet were recommended for postoperative use. The request for authorization form for Cold compression unit and Percocet 5-325mg #60 was submitted on 03/13/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Compression unit for 2 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines(www.odg-twc.com: Section: Shoulder (Acute & Chronic) updated 03/31/2014.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder, Cold compression therapy & Continuous-flow cryotherapy.

Decision rationale: The request for Cold compression unit for 2 weeks is not medically necessary. The Official Disability Guidelines note cold compression therapy is not recommended in the shoulder, as there are no published studies. The guidelines recommend the use of continuous flow cryotherapy without compression for up to 7 days post-operatively. The request for a cold compression unit for 2 weeks would exceed guidelines recommendations for the duration of use. There is a lack of documentation indicating the injured worker has been approved for the mentioned shoulder surgery and it is scheduled in the near future. Additionally, the guidelines do not recommend the use of cold compression therapy for the shoulder. As such, the request exceeds the recommendations therefore the request for cold compression unit is not medically necessary.

Percocet 5-325 mg #60 (Post Op): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain, Medications for acute pain (analgesics).

Decision rationale: The request for Percocet 5-325 mg #60 is not medically necessary. Based on the clinical documentation, the injured worker had an allergic reaction to Percocet in the form of a rash. In addition, the injured worker also complained of depression and insomnia. The Official Disability Guidelines note opioids are appropriate analgesics for somatic, neuropathic, and visceral pain. Side effects include sedation, nausea, vomiting, and constipation. There is a lack of documentation indicating the injured worker has been approved for the mentioned shoulder surgery and it is scheduled in the near future. Additionally, per the documentation, the injured worker is allergic to Percocet and develops a rash while taking the medication. Therefore, given the clinical documentation of allergic reaction to Percocet and the lack of information pertaining to the performance of the mentioned surgery, the request is not medically necessary.

