

Case Number:	CM14-0194990		
Date Assigned:	12/03/2014	Date of Injury:	01/20/2005
Decision Date:	02/10/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/20/2014

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 Minnesota. 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 52-year-old male with a date of injury of 1/20/2005. The mechanism of injury described was pulling and lifting the tailgate of a truck. The reported injuries involved the right shoulder and the lower back. Per office notes dated September 30, 2014, he had a rotator cuff repair in 2005 and 2006. A repeat MRI scan of 2011 showed acromioclavicular joint wear as well as partial tear of the rotator cuff. The shoulder was injected in August 2014 giving him significant relief. On examination shoulder elevation was 130 with some shrugging and discomfort. There was tenderness over the acromioclavicular joint, biceps tendon, rotator cuff, and posterior capsule. There was some clicking along the acromioclavicular joints. O'Brien's test was positive. Strength was 5/5. The diagnosis was impingement syndrome of the right shoulder, status post rotator cuff repair with concern about labral tear. Repeat MRI of 2011 showed partial tear of rotator cuff with persistent acromioclavicular joint wear. Other diagnoses included 3 level disc disease of the lumbosacral spine and chronic pain syndrome. A request for authorization of shoulder evaluation, decompression and resection of distal clavicle, evaluation of the labrum and possible repair, evaluation of biceps and possible release, and stabilization and evaluation of rotator cuff repair with possible repair was dated September 30, 2014. This was noncertified by utilization review as guideline criteria had not been met. A recent MRI of the shoulder was not provided to corroborate pathology. Therefore the request was not medically reasonable and necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder evaluation, decompression and resection of distal clavicle, evaluation labrum: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211.

Decision rationale: California MTUS guidelines indicate surgical considerations if there is activity limitation for more than 4 months plus existence of a surgical lesion or if there is failure to increase range of motion and strength of the musculature around the shoulder plus existence of his surgical lesion or if there is clear clinical and imaging evidence of a lesion that has been shown to benefit both in the short-term and in the long-term from surgical repair. The documentation indicates a history of rotator cuff repair in the past and a subsequent MRI scan in 2011 that showed a partial-thickness tear. There is forward elevation of the shoulder to 130 with some shrugging and discomfort. Impingement testing such as Neer and Hawkins-Kennedy are not documented. Biceps testing such as Speed's and Yergason are not documented. There is no recent MRI scan that correlates with the clinical findings. There is no comprehensive recent conservative treatment program with exercises and corticosteroid injections documented. Based upon the above, the request for a repeat right shoulder arthroscopy with decompression, evaluation of the labrum, and distal claviclectomy is not supported by guidelines and as such, the medical necessity is not substantiated.

Right shoulder labrum possible repair, evaluation of biceps and possible release and stabilization: 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, and 211.

Decision rationale: California MTUS guidelines indicate surgical considerations if there is activity limitation for more than 4 months plus existence of a surgical lesion, if there is failure to increase the range of motion with an exercise program plus existence of his surgical lesion and if there is clear clinical and imaging evidence of a lesion that is known to benefit both in the short-term and long-term from surgical repair. The documentation does not indicate a recent MRI scan with evidence of a labral tear or necessity for a biceps tenodesis. There is no evidence of a failed regimen of conservative treatment with an exercise program and corticosteroid injections. As such, the requested surgical procedure is not supported by guidelines and the medical necessity of the request is not substantiated.

Right shoulder evaluation of rotator cuff possible repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, and 211.

Decision rationale: The guidelines indicate that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of the arm elevation or rotation. The documentation indicates 5/5 strength in the right upper extremity. Elevation of the arm was reported to be 130 with some shrugging and discomfort. There is no recent imaging evidence of a rotator cuff tear that needs surgical repair. Based upon the guidelines, the request for evaluation of the rotator cuff with possible repair is not supported and as such the medical necessity is not substantiated.

Augmentin 875/12mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Zofran 8mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Neurontin 600mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

Decision rationale: Neurontin is an antiepileptic drug which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. The documentation does not indicate the presence of neuropathic pain, diabetic neuropathy, or postherpetic neuralgia. As such, the request for

Neurontin 600 mg #180 is not supported by guidelines and the medical necessity is not established. Utilization review modified the request to allow for weaning.

DME: Shoulder immobilizer: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-Op clearance (includes CBC, CMP, EKG, Chest X-ray): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

DME: Rental Polar Care, 21 days: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-89.

Decision rationale: The guideline criteria for use of opioids have only been partially met. There is no opioid pain treatment agreement documented. There is no documentation of pain and functional improvement compared to the baseline. The documentation does not indicate urine drug screens. There is no documentation of steps to avoid misuse/addiction. Utilization

review has recommended weaning. Based upon the above, the medical necessity of the request for Norco 10/325 mg #60 is not established.