

Case Number:	CM14-0200580		
Date Assigned:	12/10/2014	Date of Injury:	03/26/2003
Decision Date:	02/20/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	12/01/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Texas, Massachusetts, Nebraska
Certification(s)/Specialty: Orthopedic Surgery

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 smoker who reported an injury of unspecified mechanism on 03/26/2003. He underwent a right total shoulder arthroplasty for osteoarthritis on 06/24/2014. During that hospitalization, while he was waking up, he felt a pop in his shoulder. He was worried that he "tore something." He reported that his biggest problem was that he could not abduct his arm. He described his shoulder pain as if someone were stabbing him with an ice pick. He was using a sling. X-rays of the right shoulder on 07/30/2014 revealed that the arthroplasty was in place and not subluxed. An ultrasound of the shoulder was suggested to confirm a diagnosis but was never performed. There was no rationale or Request for Authorization included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder repair of subcapularis vs conversion to reverse total shoulder arthroplasty:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for surgery, Reverse shoulder arthroplasty

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

Decision rationale: The request for right shoulder repair of subcapularis vs conversion to reverse total shoulder arthroplasty is not medically necessary. The California ACOEM Guidelines note that referral for surgical consultation for shoulder complaints may be indicated for patients who have red flag conditions, for example, acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.; activity limitation for more than 4 months; plus existence of a surgical lesion and failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs; plus existence of a surgical lesion and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. There were no red flag conditions identified in this injured worker. There was no documentation of postoperative physical therapy. There were no imaging studies with evidence of a lesion which could benefit from surgical repair. The clinical information failed to meet the evidence based guidelines for the requested service. Therefore, this request for right shoulder repair of subcapularis vs conversion to reverse total shoulder arthroplasty is not medically necessary.

Associated surgical service: medical clearance: 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.

Associated surgical service: 1-2 day hospital stay: 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.

Associated surgical service: vascutherm cold therapy unit; 7 day rental: 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.

Associated surgical service: shoulder sling: 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.

Associated surgical service: physical therapy for the right shoulder, 2 times a week for 6 weeks: 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.

Percocet, two tablets q 4-6 hours prn/pain: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The request for Percocet, two tablets q 4-6 hours prn/pain is not medically necessary. California MTUS Guidelines recommend providing ongoing education on both the benefits and limitations of opioid treatment. The guidelines recommend the lowest possible dose should be prescribed to improve pain and function. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long pain relief lasts; and how long it takes for pain relief. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The submitted documentation lacked evidence of the injured worker's failure to respond to normal opioid analgesics. The documentation also lacked the efficacy of the medication, a complete and accurate pain assessment, and aberrant behaviors. Additionally, the request as submitted did not indicate a dosage for the Percocet. Given the above, the injured worker is not within MTUS recommended guideline criteria. As such, the request is not medically necessary.

Oxycontin 10mg, one po bid prn/pain #28: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The request for Oxycontin 10mg, one po bid prn/pain #28 is not medically necessary. The California MTUS Guidelines recommend providing ongoing education on both the benefits and limitations of opioid treatment. The guidelines recommend the lowest possible dose should be prescribed to improve pain and function. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The submitted documentation lacked evidence of the injured worker's failure to respond to normal opioid analgesics. Additionally, there was no indication of the efficacy of the medication, nor did it indicate that the medication was helping with any functional deficits. There was also a lack of complete and accurate pain assessment and aberrant behaviors. Given the above, the injured worker is not within MTUS recommended guideline criteria. As such, the request is not medically necessary.