

Case Number:	CM14-0205161		
Date Assigned:	01/02/2015	Date of Injury:	09/15/2007
Decision Date:	02/06/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/08/2014

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:

According to the records made available for review, this is a 53-year-old male with a 9/15/07 date of injury. At the time (11/17/14) of request for authorization for left shoulder arthroscopy, subacromial decompression, possible rotator cuff tear, 12 post-op physical therapy, and Norco 10/325 1 every 6 hours as needed for pain #120, there is documentation of subjective (shoulder pain) and objective (tenderness over the proximal biceps tendon with pain on full extension with the arm at 90 degrees of side abduction) findings, imaging findings (MRI of the left shoulder (6/19/14) report revealed partial-tear/tendinosis involving the distal supraspinatus with mild fatty atrophy of the supraspinatus muscle, hypertrophic changes of the acromioclavicular joint as well as a laterally downsloping acromion which narrow the acromioclavicular interval predisposing to impingement, subcortical degenerative changes of the humeral head, and biceps tendon sheath fluid), current diagnoses (left shoulder impingement), and treatment to date (medications (including ongoing treatment with Norco), shoulder injections, and physical therapy). Regarding subacromial decompression, there is no documentation of additional subjective clinical findings (pain at night) and objective clinical findings (weak or absent abduction, tenderness over rotator cuff or anterior acromial area, and positive impingement sign). Regarding Norco 10/325 1 every 6 hours as needed for pain #120, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Norco use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy: 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.

Subacromial Decompression: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Subacromial Decompression and Manipulation Under Anesthesia

Decision rationale: MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of a diagnosis of left shoulder impingement. In addition, there is documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections. Furthermore, there is documentation of subjective clinical finding (pain with active arc motion at 90 degrees). Lastly, given documentation of imaging findings (MRI of the left shoulder identifying partial-tear/tendinosis involving the distal supraspinatus with mild fatty atrophy of the supraspinatus muscle), there is documentation of imaging clinical findings (arthrogram showing positive evidence of deficit in rotator cuff). However, despite documentation of subjective (left shoulder pain), there is no documentation of additional subjective clinical findings (pain at night). In addition, despite documentation of objective (tenderness over the proximal biceps tendon) findings, there is no documentation of objective clinical findings (weak or absent abduction, tenderness over rotator cuff or anterior acromial area, and positive impingement sign).

Therefore, based on guidelines and a review of the evidence, the request for subacromial decompression is not medically necessary.

Possible Rotator Cuff Tear: 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.

12 Post-Op Physical Therapy: 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 10/325 1 Every 6 Hours As Needed for Pain #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identify that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of left shoulder impingement. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with Norco, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a

reduction in the use of medications as a result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request Norco 10/325 1 every 6 hours as needed for pain #120 is not medically necessary.