

Case Number:	CM15-0145663		
Date Assigned:	08/06/2015	Date of Injury:	11/03/2008
Decision Date:	09/10/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/27/2015

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: Minnesota, Florida
 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 (IW) is a 51-year-old female who sustained an industrial injury on 11-03-2008. Diagnoses include right shoulder instability. Treatment to date has included medications, physical therapy and surgery. According to the progress notes dated 5-8-2015, the IW reported continued pain in the armpit and the inability to raise her arm. On examination, flexion of the right shoulder was about 140 degrees, abduction was 90 degrees and external rotation was 30 degrees. Apprehension sign was positive. Passive external rotation with the arm abducted caused pain directly in front. MRI of the right shoulder on 3-15-2013 showed evidence of subacromial decompression and mild articular-sided fraying of the rotator cuff without full thickness retracted tear. A request was made for right shoulder arthroscopic capsular plication and Norco 10/325mg, #90, one tablet by mouth every hour as needed, no refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic capsular plication: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

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

Decision rationale: California MTUS guidelines indicate multiple traumatic shoulder dislocations necessitate surgery if the shoulder has limited functional ability and if muscle strengthening fails. If shoulder instability is present only with violent forceful overhead activity, activity modification is recommended. In this case the provider has documented instability on a daily basis with subluxations on overhead motion associated with axillary pain. The guidelines indicate surgery for patients who are symptomatic with all overhead activities and patients who have had 2 or 3 episodes of dislocation and instability that limited their activity between episodes. Although complete dislocations have not been documented, there is instability noted with overhead use on a daily basis. As such, the request for arthroscopic plication is supported and the medical necessity of the request has been substantiated.

Norco 10/325mg 1 by mouth ever hour as needed, #90: 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 Hydrocodone/acetaminophen Page(s): 91.

Decision rationale: Chronic pain guidelines indicate hydrocodone/acetaminophen is indicated for moderate to moderately severe pain. The usual dose is 1 or 2 tablets of 5/500 mg every 4-6 hours as needed for pain. For higher doses of hydrocodone (greater than 5 mg/ tab) and acetaminophen (greater than 500 mg/ tab) the recommended dose is usually one tablet every 4-6 hours as needed for pain. The request as stated is for Norco 10/325 one every hour as needed for pain which exceeds the guideline recommendations. As such, the request for Norco 10/325 #90 is not supported and the medical necessity of the request has not been substantiated.