

Case Number:	CM15-0149377		
Date Assigned:	08/14/2015	Date of Injury:	12/11/2002
Decision Date:	09/14/2015	UR Denial Date:	07/03/2015
Priority:	Standard	Application Received:	07/31/2015

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: California, Indiana, Oregon
 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 55 year old female who sustained an industrial injury on 12-11-02. Her initial symptoms and nature of the injury are not available for review. Diagnoses noted in the August 31, 2011 orthopedic consult include status-post bilateral carpal tunnel surgeries in 2003, status-post bilateral shoulder surgeries, most recent was January 2011 on the left shoulder, depression, anxiety, a psychiatric disability noted on psychological evaluation. The injured worker has attended pain management sessions, had nerve testing, attended physical therapy, undergone MRI, and been treated with medications. On the August 2011 exam, she complained of left sided neck pain, describing it as "burning", as well as shoulder pain, stating that it radiates down into the upper arm. She also complained of right wrist pain and numbness in both hands. The documentation revealed that her "psychological and social issues overwhelm the specific injury" and the plan was to have her follow up with the psychologist or pain management. The shoulder provider visit on 2-4-15 indicates that the December 2014 MRI reveals "recurrent right shoulder full-thickness supraspinatus tendon tear". The treatment plan recommended is a revision arthroscopic RC repair, followed by a sling for approximately 6-8 weeks following surgery. The most recent PR-2 dated 7-14-15 indicates that the injured worker presented with bilateral shoulder pain. She rated the pain "8 out of 10". She did not report any change in her pain and the report states that "she is not trying any other therapies for pain relief". The report states that her activity level has decreased and the "right shoulder surgery has been denied". Her medications include Paxil, Zanaflex, MS Contin, Trazadone, Cozaar, and Seroquel.

Diagnoses include carpal tunnel syndrome bilaterally, mood disorder, shoulder pain, entrapment neuropathy upper limb, pain disorder with both psychological factors and orthopedic condition.

IMR ISSUES, DECISIONS AND RATIONALES

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

Revision shoulder arthroscopic RC repair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. The results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. Fatty infiltration in any of the muscles of the rotator cuff lowers the success of the repair in any of the muscles (Goutallier, 2003). In this case there has already been a revision. Based on this, the request is not medically necessary.

Pre-op testing, CBC: 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 testing, UA: 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 testing, CMP: 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 testing, EKG: 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: 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: Polar care unit: 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 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. In this case, there is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity due to medications. Therefore the request is not medically necessary.