

Case Number:	CM15-0185780		
Date Assigned:	09/29/2015	Date of Injury:	04/06/2015
Decision Date:	12/04/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/21/2015

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 52 year old female, who sustained an industrial-work injury on 4-6-15. A review of the medical records indicates that the injured worker is undergoing treatment for right rotator cuff tear. Medical records dated (5-21-15 to 7-30-15) indicate that the injured worker complains of right shoulder pain caused by a high grade tear to the right rotator cuff and pain on the lateral side of the right elbow, which she thinks is the result of overuse. Following the injury she has had limited range of motion in the right shoulder and difficulty performing daily tasks. She has been attending physical therapy to alleviate pain and promote healing, but neither the pain nor the limited range of motion have resolved. The medical records also indicate worsening of the activities of daily living due to pain and limited range of motion. Per the treating physician report dated 7-30-15 the work status is with restrictions. The physical exam dated 7-30-15 reveals that there is anterior right shoulder tenderness, right shoulder range of motion with forward flexion is 120 degrees, abduction is 100 degrees and painful, and external rotation is 30 degrees and painful. The supraspinatus strength is 4 out of 5 on the right, the suprascapularis is 4 out of 5 and there are positive Hawkin's and Neer's tests on the right. The physician indicates that because the current physical therapy shoulder regimen has not resulted in significant improvement to her pain and limited range of motion that surgery is recommended. Treatment to date has included pain medication including Etodolac, diagnostics, physical therapy at least 4 sessions, work modifications, and other modalities. Magnetic resonance imaging (MRI) of the right upper extremity dated 5-13-15 reveals moderate grade mainly intrasubstance tearing of the anterior most fibers of the right supraspinatus tendon about its footprint seen on a background of

mild tendinosis. There is low to moderate grade tearing of the upper tendinous fibers of the right suprascapularis tendon near its footprint. There is a small amount of fluid in the subacromial subdeltoid bursa. No evidence of tearing of the long biceps tendon of the right shoulder. The request for authorization date was 7-31-15 and requested services included Right shoulder arthroscopic rotator cuff repair, subacromial decompression and labral debridement, Associated Service: assistant surgeon, Pre op clearance physical, Associated Services: Electrocardiogram (EKG), Associated Services: CBC, Post op physical therapy x 12 visits, Shoulder brace, Cold therapy, Norco 10-325mg #50, Colace 100mg #50 and Zofran 4mg #20. The original Utilization review dated 8-28-15 non-certified the request for Right shoulder arthroscopic rotator cuff repair, subacromial decompression and labral debridement, Associated Service: assistant surgeon, Pre op clearance physical, Associated Services: Electrocardiogram (EKG), Associated Services: CBC, Post op physical therapy x 12 visits, Shoulder brace, Cold therapy, Norco 10-325mg #50, Colace 100mg #50 and Zofran 4mg #20.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic rotator cuff repair, subacromial decompression and labral debridement: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. 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. In this case the imaging does not demonstrate full thickness rotator cuff tear. The request is not medically necessary.

Associated Service: assistant surgeon: Upheld

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

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre op clearance physical: Upheld

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

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Service: EKG: Upheld

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

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Service: CBC: Upheld

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

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post op physical therapy x12 visits: Upheld

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

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Service: Shoulder brace: Upheld

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

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated Service: Cold therapy: Upheld

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

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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Norco 10/325mg #50: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

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.

Colace 100mg #50: Upheld

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

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of stool softeners. According to the ODG Pain section, opioid induced constipation treatment, "if prescribing opioids has been determined to be appropriate, then ODG recommends, under Initiating Therapy, that Prophylactic treatment of constipation should be initiated." In this case the constipating medications are not medically necessary, so the stool softener is not medically necessary.

Zofran 4mg #20: Upheld

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

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of Zofran for postoperative use. According to the ODG, Pain Chapter, "Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use." In this case the submitted records demonstrate no evidence of nausea and vomiting or increased risk for postoperative issues. Therefore determination is not medically necessary.