

<b>Case Number:</b>	CM15-0032430		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	08/26/2011
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 54-year-old female who reported injury on 08/26/2011. The mechanism of injury was cumulative trauma. The diagnoses included ankylosis of joint; pain in joint involving shoulder region; other affections of shoulder region not elsewhere classified; lateral epicondylitis, elbow region; and rotator cuff sprain. The injured worker was noted to undergo prior shoulder surgery. Prior therapy included medications, physical therapy, and an injection. The injured worker was utilizing a Dynasplint. The injured worker's medications included Norco 5 mg. The injured worker underwent a left elbow epicondylar debridement, extensor tendon repair, and exostectomy on 06/09/2014. There was a Request for Authorization submitted for review dated 02/02/2015. The injured worker underwent an MRI of the right shoulder on 07/17/2013, which revealed evidence of a prior surgery. The injured worker had tendinopathy and a possible partial tear of the supraspinatus tendon, with slight irregularity along the inferior articular margin. There was calcific tendonitis at the insertion of the infraspinatus tendon. There was a small area of avascular necrosis in the humeral head. There were small cysts in the humeral head. There was flattening of the greater tuberosity, probably reflecting chronic micro impingement. The documentation of 01/20/2015 revealed the injured worker's symptoms had increased since the last visit. The injured worker had pain to the bilateral shoulders. The right shoulder pain was constant, and the left shoulder pain came and went. The physical examination of the right shoulder revealed a positive Neer and Hawkins. The injured worker had tenderness to palpation over the anterior and lateral aspect of the shoulder. The injured worker had a positive Hawkins and Neer on the left shoulder. There was tenderness to

palpation over the anterior and lateral aspect of the shoulder. The diagnoses included right shoulder calcific tendonitis and partial thickness tear of the rotator cuff tendon, per MRI 07/17/2013. The treatment plan included a right shoulder arthroscopy, rotator cuff repair, with 12 sessions of postoperative therapy and a preoperative clearance. Additionally, the documentation indicated a cold unit would help control pain and decrease the need for narcotic medications.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Right Shoulder Arthroscopy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate that surgical consultation may be appropriate for injured workers who have activity limitation for more than 4 months, failure to increase range of motion and strength in the musculature around the shoulder, even after exercise programs, 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. The clinical documentation submitted for review indicated the injured worker had a failure of conservative care. The MRI revealed a possible tear in the rotator cuff. However, the request as submitted failed to indicate the specific surgical intervention being requested. Given the above, the request for right shoulder arthroscopy is not medically necessary.

#### **Post Op Physical Therapy 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.

#### **Durable medical equipment rental - cold therapy unit - 10 days: 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.

**Durable medical equipment purchase - 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.

**Pre Op 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.

**Norco 5mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to meet the above criteria. The request as submitted failed to indicate the frequency for the requested med. Given the above, the request for Norco 5 mg #90 is not medically necessary.