

Case Number:	CM14-0135405		
Date Assigned:	08/29/2014	Date of Injury:	04/13/1993
Decision Date:	10/14/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	08/22/2014

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:

This is a 61 year old male with a 4/13/93 injury date. The mechanism of injury is not provided. A review of the records indicates that the patient has a history of bilateral shoulder, neck, chronic back pain syndrome, right shoulder adhesive capsulitis, right lower extremity paralysis and palsy secondary to spinal infarction and paraplegia, left knee degenerative joint disease, obesity, lower extremity wound, history of diabetes, bilateral hand numbness and tingling, and low back pain. In a follow-up on 8/8/14, the patient continues to complain of right shoulder AC joint pain. A recent injection into the AC joint resulted in relief for one hour. The provider recommended a right shoulder arthroscopy with distal clavicle excision. The provider notes that it will be difficult for his family to transfer him because of his weight and being wheelchair-bound. The provider is requesting a skilled nursing facility (SNF) for post-op care. Objective findings included tenderness over his right AC joint, pain with cross-body adduction, and positive impingement signs. A right shoulder MRI on 6/20/14 showed mild tendinosis of the rotator cuff without evidence of tear, mild degenerative changes of the superior labrum, and fatty atrophy of the cuff muscles. Diagnostic impression: right shoulder AC joint arthritis. Treatment to date: right shoulder AC joint injection. A UR decision on 8/20/14 denied the request for right shoulder arthroscopy with distal clavicle excision (DCE) on the basis that there were limited objective findings on shoulder exam and there was no documented report of continuous conservative therapy directed to the right shoulder. The requests for 2-day inpatient stay, post-op physical therapy, cryo unit and sling, percocet, and oxycontin, were denied because the surgical procedure was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with distal clavicle excision: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines for surgery-Partial claviclectomy

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.

Decision rationale: ODG supports partial claviclectomy (including Mumford procedure) with imaging evidence of significant AC joint degeneration along with physical findings (including focal tenderness at the AC joint, cross body adduction test, active compression test, and pain reproduced at the AC joint with the arm in maximal internal rotation may be the most sensitive tests), and pain relief obtained with an injection of anesthetic for diagnostic purposes. Non-surgical modalities includes at least 6 weeks of care directed towards symptom relief prior to surgery including anti-inflammatories and analgesics, local modalities such as moist heat, ice, or ultrasound. In the present case, the subjective and objective clinical evidence is consistent with AC joint arthritis, and there is temporary relief with a diagnostic AC joint injection, although the MRI report does not mention evidence of AC joint arthropathy. However, there is minimal evidence in the documentation that the patient has tried conservative methods such as physical therapy directed to the current issue, anti-inflammatories, and cortisone injection (therapeutic as opposed to diagnostic). Therefore, the request for right shoulder arthroscopy with distal clavicle excision is not medically necessary.

Two (2) day inpatient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, ICD-9 Index

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

Decision rationale: CA MTUS does not address this issue. ODG recommends that right shoulder arthroscopy with subacromial decompression be performed on an outpatient basis. A right shoulder arthroscopy with distal clavicle excision is similar with respect to extent and duration, and can be performed on an outpatient basis as well. A 2-day inpatient stay cannot be recommended in this case. In addition, the surgical procedure was not certified. Therefore, the request for two (2) day inpatient stay is not medically necessary.

12 Post op physical therapy sessions: Upheld

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

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

Decision rationale: CA MTUS does not address this issue. ODG recommends 24 physical therapy sessions over 14 weeks after shoulder arthroscopy for impingement syndrome. However, the requested 12 sessions of post-op physical therapy is not medically necessary because the surgical procedure is not medically necessary. Therefore, the request for 12 post-op physical therapy sessions is not medically necessary.

1 Vascutherm cold therapy unit and shoulder sling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic)

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

Decision rationale: CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the present case, cryotherapy is not necessary because the surgical procedure is not considered medically necessary. Therefore, the request for 1 vascutherm cold therapy unit and shoulder sling are not medically necessary.

1 Prescription of Percocet 10/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Page(s): 79-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter.

Decision rationale: CA MTUS states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time, such as in a postoperative setting. In the present case, post-op Percocet is not necessary because the surgical procedure is not considered medically necessary. Therefore, the request for 1 Prescription of Percocet 10/325mg #90 is not medically necessary.

1 Prescription of Oxycontin 10mg #28: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Page(s): 79-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter.

Decision rationale: CA MTUS states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time, such as in a postoperative setting. In the present case, post-op Oxycontin is not necessary because the surgical procedure is not considered medically necessary. Therefore, the request for 1 Prescription of Oxycontin 10mg #28 is not medically necessary.