

Case Number:	CM15-0177474		
Date Assigned:	09/29/2015	Date of Injury:	09/12/2013
Decision Date:	12/03/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/09/2015

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 57 year old male, who sustained an industrial injury on 9-12-13. The documentation on 8-5-15 noted that the injured worker states his thumb pain has decreased partially. The injured worker complains of right shoulder pain and rates pain level 3 out of 10 with activity, which can increase to a 7 out of 10 with reaching over the shoulder level or behind and sleeping on the right side. There is numbness in his right shoulder at the surgical sites. Shoulder examination noted active abduction is 150 degrees right and 165 degrees left; forward flexion is 155 degrees right and 160 degrees left; extension is 40 degrees bilaterally and adduction is 30 degrees right and 45 degrees left. The Qualified Medical Examiner on 7-24-15 noted that the injured workers right shoulder abduction was 95 degrees. The diagnoses have included right rotator cuff tear. Treatment to date has included left thumb basilar joint injection on 7-8-15; norco; soma and right shoulder rotator cuff repair on 2-27-14. The documentation noted that the injured workers blood sugars increased following a left thumb basilar joint injection but did return back down. The physical therapy initial examination for the injured workers hands and lower back was on 6-30-15 to begin 2 times a week for 6 weeks for therapeutic exercises and manual therapy. The physical therapy discharge Summary on 8-20-15 noted no progress. The documentation on 8-5-15 noted that the injured worker is holding off on therapy for the right shoulder based on the weakness in the right shoulder and the recurrent rotator cuff tear. Magnetic resonance arthrogram right shoulder on 7-1-15 revealed there is complete rupture of the supraspinatus tendon, which is retracted approximately 5.2 centimeter from the expected insertion of the greater tuberosity and there is associated moderate-to-severe

atrophy of the supraspinatus muscle. Right shoulder X-ray on 11-11-14 noted there are cystic changes about the greater tuberosity and there appears to be some medial acromial inferior spurring and a type 2 acromion on outlet view. The original utilization review (9-3-15) denied the request for shoulder arthroscopy; associated surgical services, cold therapy unit purchase; associated surgical services, ultrasling; pre-operative medical clearance; associated surgical services, physical therapy 12 sessions; norco and ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder Arthroscopy: 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: 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). CA MTUS/ACOEM is silent on the issue of grafts for massive rotator cuff tears. According to the ODG, Shoulder section, Grafts for the rotator cuff, "Under study. Over the past few years, many biologic patches have been developed to augment repairs of large or complex rotator cuff tendon tears. These patches include both allograft and xenografts. Regardless of their origins, these products are primarily composed of purified type I collagen. There is a lack of studies demonstrating which ones are effective. For short-term periods, restoring a massive rotator cuff tendon defect with synthetic grafts can give significant pain relief, but there is still some risk of new tears." In this case the request is for revision of a massive rotator cuff tear. As the guidelines do not recommend the use of graft in massive rotator cuff tears, the determination is not medically necessary.

Associated surgical services; Cold therapy unit purchase: 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 surgical services; Ultrasling: 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 operative 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 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 surgical services; Physical therapy 12 sessions: 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: Upheld

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

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

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. Further, the quantity is not specified. Therefore, the request is not medically necessary.

Ambien: 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 Ambien. According to the ODG, Pain Section, Zolpidem (Ambien) is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. There is no evidence in the records of insomnia to warrant Ambien. Therefore, the request is not medically necessary.