

Case Number:	CM13-0052616		
Date Assigned:	12/30/2013	Date of Injury:	07/18/2011
Decision Date:	05/19/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	11/15/2013

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 41-year-old claimant who was injured on 07/14/11. Recent clinical record for review from 12/04/13 indicates multiple orthopedic injuries including the left ankle with numbness into the left foot, left shoulder pain, right shoulder pain, bilateral wrist pain, bilateral knee pain, neck pain and low back complaints. Current objective findings showed the wrist to be with generalized tenderness to palpation with diminished range of motion. The shoulders were with weakness with flexion, abduction, external rotation and no other findings. Lumbar spine was with positive left sided straight leg raise. The bilateral knees were with tenderness to the anterior aspect of the medial joint line and the left ankle was with tenderness over the lateral aspect to palpation. Records indicated current clinical request to include a left shoulder arthroscopy with decompression. A repeat left shoulder MRI, a right shoulder MRI, electrodiagnostic studies to the upper extremities, prescriptions of Prilosec, Medrox, Ultram, Vicodin, postoperative physical therapy, preoperative medical clearance, a postoperative use of a combocare IV unit and a heat/cold therapy system. Previous imaging is not available for review in this case. Specific to the claimant's left shoulder there is no documentation of recent conservative care or measures.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPY, SUBACROMIAL DECOMPRESSION, POSSIBLE ARTHROTOMY QTY: 1.00: Upheld

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

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

Decision rationale: California ACOEM guidelines would not support the acute role of surgical process. CA MTUS states, "Conservative care, including cortisone injections, can be carried out for at least three to six months before considering surgery." Records for review in this case fail to demonstrate recent clinical imaging or previous clinical imaging for review. This is coupled with lack of documentation of conservative care including injection therapy. The acute need of a shoulder arthroscopy given the claimant's current clinical presentation would not be indicated. The request for left shoulder arthroscopy, suabromial decompression, and possible arthrotomy is not medically necessary.

MRI OF THE LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196.

Decision rationale: Based on California ACOEM guidelines, shoulder MRI would not be indicated. Current clinical records, while demonstrating motion deficit, fail to demonstrate evidence of a red flag or physiological evidence of tissue insult or weakness, I would support the acute need of shoulder imaging. The specific request in this case would not be supported as medically necessary.

MRI OF THE RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196.

Decision rationale: Based on California ACOEM guidelines, the shoulder MRI would not be indicated. Current clinical records, while demonstrating motion deficit, fail to demonstrate evidence of a red flag or physiological evidence of tissue insult or weakness, I would support the acute need of shoulder imaging. The specific request in this case would not be supported as medically necessary.

ELECTROMYOGRAM (EMG) OF THE BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: California ACOEM guidelines would not support the role of electrodiagnostic studies. Clinical records were reviewed in this case and fail to demonstrate upper extremity neurologic finding that would necessitate the acute need of electrodiagnostic studies. The role of the above tests in this case would not be supported. The request for Electromyogram of the bilateral upper extremities is not medically necessary.

NERVE CONDUCTION VELOCITY (NCV) STUDY OF THE BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: California ACOEM guidelines would not support the role of electrodiagnostic studies. Clinical records were reviewed in this case and fail to demonstrate upper extremity neurologic finding that would necessitate the acute need of electrodiagnostic studies. The role of the above tests in this case would not be supported. The request for nerve conduction velocity study of the bilateral upper extremities is not medically necessary.

PRESCRIPTION OF PRILOSEC 20MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids, Gi Symptoms & Cardiovascular Risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Nsaids, Gi Symptoms & Cardiovascular Risk Page(s): 68-69.

Decision rationale: CA MTUS guidelines would not support the role of Prilosec. Prilosec a protective proton pump inhibitor can be indicated for concordant use with nonsteroid medication if significant GI risk factor is present. First and foremost there is no documentation of current nonsteroidal usage in this case. Coupled with the fact that there was not documentation of significant GI risk factor, the use of this agent would not be indicated at this time. The request for Prilosec 20mg, #60 is not medically necessary.

PRESCRIPTION OF MEDROX 120GM, #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Topical Analgesics Page(s): 111-113.

Decision rationale: CA MTUS guidelines would not support the topical role of Medrox. Medrox is a topical methylsaclylate menthol and capsaicin. Capsaicin is only recommended as a second line agent when first line agents in terms of joint complaints have failed. Records in this case fail to demonstrate significant first line agents for the claimant's multiple orthopedic complaints. The acute need of this topical agent would not be indicated as medically necessary.

PRESCRIPTION OF ULTRAM 50MG, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Opioids-Tramadol Page(s): 91-94.

Decision rationale: CA MTUS guidelines would not support the role of Ultram. Ultram is to be used with caution in the chronic setting with guideline criteria not supporting its use beyond 16 weeks. Records in this case indicate chronic injury for which medication has been utilized for greater than a 16 weeks period of time. The specific role of continuation of Ultram would not be supported. The request for Ultram 50mg, #120 is not medically necessary.

PRESCRIPTION OF VICODIN ES #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Opioids-Criteria For Use Page(s): 76-80.

Decision rationale: CA MTUS guidelines would not support the continued role of Vicodin. At present, there is no indication of acute benefit from the use of this short acting narcotic analgesic. The claimant continues to complain of pain about multiple joints Final Determination Letter for IMR Case Number CM13-0052616 6 with orthopedic issue. Based on lack of documentation of significant benefit, the continued role of this agent would not be supported. The request for Vicodin ES #60 is not medically necessary.

POSTOPERATIVE PHYSICAL THERAPY, QTY: 12.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: California MTUS postsurgical rehabilitative guidelines would not support the role of postoperative physical therapy as the need for operative intervention has not been supported. The request for Postoperative Physical Therapy is not medically necessary.

PREOPERATIVE CLEARANCE BY AN INTERNIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ogd-Twc, Integrated Treatment/Disability Duration Guidelines, Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College Of Occupational And Environmental Medicine (ACOEM), 2nd Edition, (2004), 7 Independent Medical Examinations And Consultations, Page 127.

Decision rationale: California ACOEM guidelines also would not support the role of preoperative medical clearance as the need for operative intervention has not been established. The request for Preoperative Clearance by an internist is not medically necessary.

COMBO CARE 4 STEM TRIAL (DAYS) QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (Tens), Page(s): 114-1.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Unit Page(s): 188.

Decision rationale: CA MTUS guidelines would not support the role of a postoperative combocare IV unit as the need for operative intervention has not been established. The request for Combo Care 4 STEM TRIAL (days) QTY: 30.00 is not medically necessary.

HOT COLD CONTRAST SYSTEM WITH COMPRESSION TRIAL (DAYS) QTY: 60.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), ODG-TWC; ODG Treatment, Integrated Treatment/Disability Guidelines, Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 337-339.

Decision rationale: The role of any form of combination therapy device is not recommended as medically necessary. The specific role of this device in the postoperative setting for a surgery that has not been supported also would not be indicated. The request for Hot Cold contrast system with compression trial is not medically necessary.