

<b>Case Number:</b>	CM13-0061086		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	04/01/2002
<b>Decision Date:</b>	04/01/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Alaska. 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 physician 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:

The patient is a 56-year-old female who reported an injury on 04/01/2002. The mechanism of injury was noted to be a cumulative trauma. The patient had a right shoulder rotator cuff repair in 2010, and a cervical decompression and fusion in 2013. The patient was noted to be certified for a left shoulder arthroscopy, subacromial decompression, and acromioclavicular (AC) joint resection. The patient was noted to have intermittent pain, and the medications were noted to give the patient functional improvement and pain relief. The patient had positive tenderness over the paracervical musculature, and positive muscle spasm in the paracervical musculature with a negative Spurling's test. The patient's diagnoses were noted to include status post cervical spine fusion, chronic cervical pain, right shoulder status post arthroscopy with rotator cuff repair, impingement syndrome left shoulder, left shoulder partial rotator cuff tear, and frozen bilateral shoulders. The request was made for a pain management consultation for chronic pain and possible facet injections, and medication refills, as well as postoperative physical therapy and vascultherm postoperatively.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Eighteen (18) sessions of postoperative physical therapy, three (3) times a week for six (6) weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10 and 27.

**Decision rationale:** The Postsurgical Treatment Guidelines indicate that postsurgical treatment for arthroscopic surgery of the shoulder for a rotator cuff is twenty-four (24) visits over fourteen (14) weeks, and the initial course of therapy should be one-half the course of recommended therapy. The request would be supported for twelve (12) sessions. Per the submitted request, there was a lack of documentation indicating the part of the body that would be treated with the postoperative physical therapy. There was a lack of documentation indicating a necessity for eighteen (18) sessions of physical therapy. Given the above, the request is not medically necessary.

**Tramadol ER 150mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list.

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

**Decision rationale:** The Chronic Pain Guidelines indicate that opiates are the appropriate treatment for chronic pain. There should be documentation of an objective increase in function, objective decrease in the visual analog scale (VAS) score, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated that the medications were giving the patient functional improvement and pain relief. However, there was a lack of documentation indicating objective improvement in function, objective decrease in the VAS score, and evidence that the patient is being monitored for aberrant drug behavior and side effects. Additionally, there was a lack of documentation indicating the duration the patient had been on this medication. Given the above, the request for Tramadol ER 150 mg #30 is not medically necessary.

**Cyclobenzaprine 7.5mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The Chronic Pain Guidelines indicate that muscle relaxants are prescribed as a second-line option for short-term treatment in acute low back pain, and should be used for less than three (3) weeks. The guidelines indicate that there should be documentation of objective functional improvement to support ongoing usage. The clinical documentation submitted for review failed to indicate the duration the patient had been on the medication. Additionally, there was a lack of documentation of objective functional improvement to support ongoing usage. Given the above, the request for cyclobenzaprine 7.5 mg #30 is not medically necessary.

**Ondansetron 4mg #30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, ondansetron (Zofran)

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

**Decision rationale:** The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. The clinical documentation submitted for review indicated that the physician was prescribing the medication for the patient to counteract the effects of nausea from NSAIDs prophylactically. There was a lack of documentation indicating the efficacy of the requested medication. Additionally, there was a lack of documentation indicating the duration the patient had been on the medication. Given the above, the request for ondansetron 4 mg #30 is not medically necessary.

**Vascutherm 4 with deep vein thrombosis cold compression for thirty-five (35) days: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Venous thrombosis

**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, Continuous Flow Cryotherapy, Knee & Leg Chapter, Venous Thrombosis

**Decision rationale:** The Official Disability Guidelines recommend continuous flow cryotherapy for seven (7) days postoperatively including home use, and they recommend that a patient who is at high risk for developing venous thrombosis should be identified prior to surgery and provided oral prophylactic measures as necessary. There was a lack of documentation indicating the necessity for a cold compression therapy unit postoperatively. There was a lack of documentation indicating that the patient had a necessity for the use of the unit for thirty-five (35) days. Given the above, the request for vascutherm 4 with deep vein thrombosis cold compression for thirty-five (35) days is not medically necessary.

**Request for pain management consultation for/possible facet injections:**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, ongoing management Page(s): 78.

**Decision rationale:** The Chronic Pain Guidelines recommend the consideration of a consultation with a multi-disciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in three (3) months. The

clinical documentation submitted for review failed to provide documentation of the rationale for referral to the pain management consultation physician. The patient had positive tenderness over the paracervical musculature, and positive muscle spasm in the paracervical musculature with a negative Spurling's test. There was a lack of documentation of myotomal or dermatomal findings to support the referral for facet injections. Given the above, the request for decision for pain management consultation for/possible facet injections is not medically necessary.