

Case Number:	CM13-0065969		
Date Assigned:	01/03/2014	Date of Injury:	08/17/2007
Decision Date:	07/28/2014	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	12/16/2013

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 44-year-old female sustained an industrial injury on 8/17/07. The injury occurred while pushing a cleaning cart. The patient was status post right shoulder arthroscopy on 3/31/10. The 12/9/13 utilization review conditionally non-certified the requests for right shoulder revision arthroscopy, related services, durable medical equipment and medications as there was additional information that was reasonably necessary in order to render a decision. The provider was asked to indicate the specific surgery procedure to be performed on the right shoulder. The 12/19/13 appeal letter indicated that the patient was diagnosed with persistent right shoulder pain with a probable SLAP tear and rotator cuff tendonitis status post arthroscopy. The patient presented on 10/15/13 with persistent right shoulder pain especially with abduction and at night. Physical exam documented active abduction 150 degrees, external rotation 80 degrees, pain with motion, positive apprehension and lift-off maneuvers, and positive impingement sign. X-rays of the right shoulder revealed some degenerative changes about the acromioclavicular (AC) joint. The 10/10/13 right shoulder MR arthrogram revealed cuff tendinosis without tear, minor marginal fraying along the biceps tendon, partial detachment of worn posterior labrum, capacious glenohumeral joint volume, and degenerated AC joint. The patient was to continue physical therapy and was prescribed medications. On 12/2/13, the patient presented with continued right shoulder pain. Physical exam revealed tenderness about the biceps tendon and AC joint. There was 130 degrees of abduction and flexion, 60 degrees external rotation, significant weakness, and positive supraspinatus and impingement tests. The patient had failed conservative treatment, including physical therapy and medications. Shoulder arthroscopy was requested for debridement of the SLAP tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 right shoulder revision arthroscopy: Overturned

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, Surgery for SLAP repair.

Decision rationale: The Official Disability Guidelines recommend surgery for Type II SLAP lesions. Surgical intervention may be considered for patients With SLAP lesions failing conservative treatment. Guideline criteria have been met. This patient has imaging findings consistent with a Type II lesion and has failed reasonable conservative treatment. The utilization review conditionally non-certified the original request as the specific arthroscopic procedure was not identified. The treating physician stated in his appeal that shoulder arthroscopy was requested for debridement of the SLAP tear. Therefore, this request for right shoulder revision arthroscopy is medically necessary.

8 physical therapy visit: Overturned

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

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

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for impingement syndrome suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. Guideline criteria have been met. Therefore, this request for 8 physical therapy visits is medically necessary.

1 pain pump: 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, Postoperative Pain Pump.

Decision rationale: The California MTUS guidelines are silent regarding this device. The Official Disability Guidelines state that post-operative pain pumps are not recommended. Guidelines state there is insufficient evidence to conclude that direct infusion is as effective as or

more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. Three recent moderate quality randomized controlled trials did not support the use of pain pumps. Given the absence of guideline support for the use of post-operative pain pumps, this request for one pain pump is not medically necessary.

30 days rental of motorized hot/cold unit: 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, Continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding hot/cold therapy units. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. A motorized hot/cold therapy unit was requested for 30 days rental. There is no compelling reason presented to support the medical necessity of this device in excess of guideline recommendations. Therefore, this request for motorized hot/cold therapy unit for 30 days rental is not medically necessary.

1 pro-sling with abduction pillow: 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, Postoperative abduction pillow sling.

Decision rationale: The California MTUS are silent regarding post-op abduction pillow slings. The Official Disability Guidelines state that these slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. This patient has a SLAP lesion and arthroscopic debridement is planned. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request for purchase of one pro-sling with abduction pillow is not medically necessary.

Sprix 15.75mg nasal spray: 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 (Chronic), Sprix (Ketorolac Tromethamine Nasal Spray).

Decision rationale: The California MTUS guidelines are silent regarding Sprix spray. The Official Disability Guidelines recommend Ketorolac tromethamine (Sprix Nasal Spray) for the short-term management of moderate to moderately severe pain requiring analgesia at the opioid level. The total duration of use of this intranasal formulation, as with other Ketorolac formulations, should be for the shortest duration possible and not exceed 5 days. Guideline criteria have not been met. The specific quantity of this medication or duration of use has not been specified. The patient has been prescribed opioid medication for post-operative pain management. There is no compelling reason presented to support the medical necessity of Sprix spray in addition to opioid medication. Therefore, this request for Sprix 15.75mg nasal spray is not medically necessary.

60 Hydrocodone/APAP 10/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): 76-80.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines support the use of Hydrocodone/acetaminophen (Norco) for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Short-acting opioids, also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling both acute and chronic pain. Guideline criteria have been met for the post-operative use of Norco. The patient is currently using Norco 10/325 mg for pain management, with a prescription indicating use twice daily. The treating physician has recommended the use of Norco to control anticipated moderate to severe post-op pain. The additional prescription is reasonable to address a higher need for opioid medication during in the short term. Therefore, this request for 60 Hydrocodone/APAP 10/325mg is medically necessary.

100 Omeprazole 20mg: Overturned

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 (ODG) Pain (Chronic), Proton pump inhibitors (PPIs).

Decision rationale: The California MTUS contains no mention of the use of proton-pump inhibitors, such as Prilosec, for any condition other than chronic pain when the patient is also being prescribed non-steroidal anti-inflammatory drugs (NSAIDs). The Official Disability Guidelines recommend the use of proton pump inhibitors for patients at risk for gastrointestinal

events and indicate these medications should be used at the lowest dose for the shortest possible amount of time. Guideline criteria have been met. Records indicate that the patient has experienced gastrointestinal distress due to the long-term use of Norco. Given the anticipated increased need for Norco during the post-operative period, this request is reasonable. Therefore, this request for 100 Omeprazole 20mg is medically necessary.

60 Tramadol ER 150mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Tramadol Page(s): 76-80, 93-94, 113.

Decision rationale: The California MTUS indicate that opioids, such as Tramadol, are recommended for moderate to moderately severe pain. Extended release opioids have the proposed advantage of stabilizing medication levels and providing round the clock analgesia. In general, continued and long-term use of opioids is contingent upon a satisfactory response to treatment that may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. If there is no overall improvement in function, discontinuation is recommended. The treating physician has requested Tramadol for long-acting control of post-operative pain; however the patient is currently prescribed Tramadol at this level. The medically necessary of an additional prescription during the post-operative period is not apparent. Additionally, there is no objective documentation of functional benefit derived from prior use of Tramadol. Therefore, this request for 60 Tramadol ER 150mg is not medically necessary.

1 orthopedic re-evaluation within 6 weeks: Overturned

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, Office visits.

Decision rationale: The California MTUS does not specifically address office follow-up visits. The Official Disability Guidelines recommend evaluation and management office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Routine follow-up orthopedic office visits during the post-operative period are consistent with guidelines. Therefore, this request for one orthopedic re-evaluation within 6 weeks is medically necessary.