

Case Number:	CM13-0071598		
Date Assigned:	01/08/2014	Date of Injury:	11/16/2010
Decision Date:	12/16/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	12/27/2013

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 Orthopaedic 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 63-year-old female patient care technician sustained an industrial injury on 11/16/10, due to cumulative trauma. Past medical history was positive for hypertension, diabetes, and hyperlipidemia. The patient underwent right knee arthroscopic subtotal medial meniscectomy and partial lateral meniscectomy on 9/27/13 with 6 post-op physical therapy visits completed. The 11/5/13 treating physician report indicated the patient was doing well after her right knee surgery and going to physical therapy. She reported intermittent right knee pain, and continued right shoulder and neck pain. She was taking Norco 10/325 mg 1 or 2 a day as needed and using topical creams which helped quite a bit. Right shoulder exam documented acromioclavicular joint tenderness, and positive impingement and Neer's test. Range of motion testing documented flexion 160, abduction 150, extension 30, internal rotation 60, and external rotation 70 degrees. Grip strength was 60/50/50 right and 80/83/86 left. Right knee exam documented a slightly stiff gait with no limp, 50% squat bilaterally, synovitis, effusion, and range of motion 0-100 degrees. The diagnosis included right shoulder impingement similar to posttraumatic arthrosis of the acromioclavicular joint. The treatment plan recommended completion of post-op physical therapy 2x6 and requested right shoulder arthroscopic subacromial decompression and partial distal claviclectomy. Medications were renewed including Norco 10/325 #60 dispensed, Naprosyn 550 mg #60, and topical creams of Ketoprofen, Gabapentin, and Tramadol. The 12/16/13 utilization review denied the request for right shoulder arthroscopic surgery as there was no documentation of imaging or x-rays findings and no evidence of comprehensive conservative treatment failure. The request for 12 additional post-op physical therapy visits for the right knee was modified to 6 visits consistent with post-surgical treatment guideline recommendations. The request for Norco 10/350 mg #60 was modified to #30 to allow for possible weaning as there was no documentation of a maintaining increase in function or

decrease in pain with the use of this medications. The request for Naprosyn 550 mg #60 was denied as there was no documentation of decreased pain or increased function with this medication. The request for topical creams was denied as there was no guideline support for the individual compounds.

IMR ISSUES, DECISIONS AND RATIONALES

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

R Shoulder Arthroscopy, SAD, Partial Distal Claviclectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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, Surgery for Impingement Syndrome

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have not been met. There is no documentation of imaging findings of impingement or a positive diagnostic impingement injection test. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, the request is not medically necessary.

Post Op PT 2X6 R Knee: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: The California Post-Surgical Treatment Guidelines for meniscectomy suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 12/16/13 utilization review modified this request for 12 additional post-op physical therapy visits to 6 visits, within the recommended general course total of 12 visits. Records indicated the patient had completed 6 visits to date. There is no compelling reason to support the medical necessity of

supervised physical therapy beyond the recommended general course of post-surgical care and previously certified treatment, at this time. Therefore, the request is not medically necessary.

Norco 10/350 #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/Acetaminophen Page(s): 76-80, 91.

Decision rationale: The California MTUS guidelines support the use of Norco for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. On-going management requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. Guideline criteria have not been met for on-going use of Norco in the absence of guideline required documentation. There is no documentation of reduced pain, increased function, or improved quality of life relative to medication use in the progress reports since 5/21/13. The 12/16/13 utilization review recommended modification of Norco 10/350 from #60 to #30 to allow for weaning. There is no compelling rationale to support on-going use of this medication in the absence of documented functional improvement. Therefore, the request is not medically necessary.

Naprosyn 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti Inflammatory Drugs)..

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 67-72.

Decision rationale: The California MTUS guidelines state non-steroidal anti-inflammatory drugs (NSAID), such as Naprosyn, are indicated for short term lowest dosage treatment of symptoms associated with osteoarthritis. Guidelines indicate that there is no evidence of long-term effectiveness for pain or function. Guideline criteria have not been met for continued use of this medication. There is no current pain assessment indicating the level of pain or what benefit has been achieved with the use of this medication. There is no current functional assessment or documentation of objective functional benefit with use of this medication. Therefore, the request is not medically necessary.

Topical Creams Keto, Tram, Gaba: Upheld

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

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

Decision rationale: The California MTUS state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines indicate that topical analgesics in general are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There are no high-quality literary studies or guidelines which support the safety or efficacy of tramadol utilized topically. MTUS guidelines specifically do not recommend gabapentin for topical use. Guidelines state that Ketoprofen is not FDA-approved for topical use given the extremely high incidence of photocontact dermatitis. Given the absence of guideline support for all components of this topical cream, the request is not medically necessary.