

Case Number:	CM14-0001935		
Date Assigned:	01/22/2014	Date of Injury:	10/18/2010
Decision Date:	07/03/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/06/2014

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:

The injured worker is a 33 year old female who reported an injury on 10/18/2010 after she assisted a patient with a transfer. The injured worker reportedly sustained an injury to her left upper extremity and cervical spine. It was documented that the injured worker had minimal acromioclavicular osteoarthritis, and evidence of infraspinatus tendinitis. The injured worker's treatment history has included physical therapy, acupuncture, and multiple medications. The injured worker underwent a cervical discectomy on 06/30/2013. The injured worker was evaluated on 10/17/2013. It was documented that the injured worker had tenderness to palpation over the dorsum of the left wrist which caused limited range of motion. The injured worker's diagnoses included ganglion cyst of the left wrist, left wrist pain, and status post cervical spine discectomy. The treatment recommendations included Naprosyn 500 mg, Flector patch 1.3%, and Ultram 50 mg. The injured worker was evaluated on 12/12/2013. Treatment recommendations were made to include left shoulder arthroscopy. The injured worker's diagnosis included impingement syndrome of the left shoulder. However, no physical findings were provided at that appointment to support the request. A Request for Authorization dated 12/12/2013 included surgery for left shoulder impingement, and medication refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPY, DECOMPRESSION OF SUBACROMIAL SPACE WITH PARTIAL ACROMIOPLASTY, WITH OR WITHOUT CORACOACROMIAL RELEASE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Page(s): 119. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Disorders.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: The ACOEM Guidelines recommend surgical intervention for the shoulder when there are significant activity limitations, supported by physical findings upon examination corroborated by an imaging study that has failed to respond to conservative treatments. The clinical documentation submitted for review does indicate that the patient has multiple body part pain generators. Although, it is noted within the documentation that the injured worker has previously had conservative treatment, there is no documentation that the patient has had conservative treatment specifically related to the left shoulder. Additionally, the clinical documentation does not include any recent evaluation of the injured worker to support significant limitations that would benefit from surgical intervention. As such, the requested left shoulder arthroscopy and decompression of the subacromial space with partial acromioplasty with or without coracoacromial release is not medically necessary or appropriate.

FLECTOR PATCH 1.3%, #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 46-48.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60.

Decision rationale: The MTUS Chronic Pain Guidelines recommends the ongoing use of medications in the management of chronic pain be supported by documented functional benefit and a quantitative assessment of pain relief. The injured worker's most recent clinical evaluation does not provide any evidence of functional benefit or pain relief resulting from medication usage. Therefore, the continued use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly define a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Flector patch 1.35 #30 is not medically necessary or appropriate.

ULTRAM 50MG, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRAMADOL (ULTRAM) Page(s): 119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The MTUS Chronic Pain Guidelines recommends the ongoing use of opioids be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration. However, the most recent physical evaluation for this injured worker does not include functional benefit, a quantitative assessment of pain relief, or evidence of side effects that are managed. The clinical documentation does not provide any evidence that the injured worker is monitored for aberrant behavior. Furthermore, the request does not include a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ultram 50 mg #30 is not medically necessary or appropriate.

NAPROSYN 500MG, #30 WITH 1 REFILL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60 AND 67.

Decision rationale: The MTUS Chronic Pain Guidelines does recommend the use of nonsteroidal anti-inflammatory drugs in the management of chronic pain. However, the documentation submitted for review does indicate that the injured worker has been on this medication for an extended period of time. The MTUS Chronic Pain Guidelines recommends that medications used in the management of chronic pain be supported by documentation of functional benefit, and evidence of pain relief. The injured worker's most recent clinical evaluation does not provide any evidence of pain relief or functional benefit resulting from medication usage. Furthermore, the request as it is submitted does not clearly define a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary and appropriate.