

Case Number:	CM14-0010368		
Date Assigned:	02/21/2014	Date of Injury:	03/30/2013
Decision Date:	09/12/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	01/24/2014

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 Internal Medicine and is licensed to practice in Texas. 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 61 year old male injured on 03/30/13 when he was pushing and pulling a computer work station on wheels throughout the day resulting in pain and discomfort to his left shoulder. Current diagnoses include cervical/lumbar spine musculoligamentous sprain/strain, bilateral upper/lower extremity radicular pain and paresthasias, status post bilateral carpal tunnel release, lateral L4-5 stenosis, and left shoulder full thickness rotator cuff tear. Prior treatments include physiotherapy, medication management and corticosteroid injections without sustained relief. Magnetic resonance image performed in November of 2013 revealed full thickness tear of the supraspinatus tendon. The clinical note dated 12/06/13 indicates the injured worker presented complaining of continuous pain on the left side of his neck with pain radiating to the left shoulder. The injured worker rated his pain at 2/10 in addition to left shoulder pain rated at 3-4/10. The injured worker also complained of lower back pain radiating to his left hip rated at 2-3/10 increasing with prolonged sitting, lifting, and pushing heavy objects. Physical examination revealed decreased range of motion of the left shoulder, positive drop arm test, Neer's sign, and Hawkins' sign positive to the left shoulder with no other abnormalities noted on assessment. Current medications include Ambien 10mg every night, Soma and Norco 10/325mg three times a day. The initial request for left shoulder arthroscopy with rotator cuff repair and subacromial decompression, assistant surgeon, and cold therapy unit was certified. The request for internal medicine clearance was non-certified. The request for postoperative physical therapy x 24 (left shoulder) was modified for twenty sessions. The request for transportation to and from the facility (frequency and duration not specified), Menthoderm gel 120 grams, and Flurbiprofen 20% gel, 120 grams were non-certified. The request for Soma 350mg #60, Norco 10/325mg #30, and Ultracet 325mg #50 were modified on 01/13/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERNAL MEDICINE CLEARANCE: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Preoperative testing, general.

Decision rationale: As noted in the Official Disability Guidelines, the decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and that undergoing intermediate-risk surgery who have additional risk factors. The injured worker is a 60 year old male scheduled to undergo a moderate risk surgical procedure. It is unknown the extent of the injured workers' prior medical history based on the documentation provided. Based on the patient's age and risk factors, the request for Internal Medicine clearance is supported as medically necessary.

POST-OP PHYSICAL THERAPY X24 (LEFT SHOULDER): Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Physical Medicine Page(s): 98.

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 24 visits over 14 weeks for the treatment of post-surgical treatment of arthroscopic rotator cuff repair and allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. The request meets current allowable physical therapy guidelines for frequency and duration. As such, the request for post-op physical therapy x24 (left shoulder) is recommended as medically necessary.

TRANSPORTATION TO AND FROM THE FACILITY (FREQUENCY AND DURATION NOT SPECIFIED): 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 Other Medical Treatment Guideline or Medical Evidence: Aetna, Clinical Policy Bulletins Number: 0218, Subject: Home Health Aides Policy.

Decision rationale: Current standard of care practices indicate custodial care, babysitting services, transportation and house cleaning are generally not considered medically necessary. Additionally, the documentation does not address the patient's lack of transportation to/from to location requesting services which is not specified. It is not indicated in the documentation that the injured worker has attempted other means of transportation prior to the request for assistance. As such, the request for transportation to and from the facility (frequency and duration not specified) is cannot be recommended as medically necessary at this time.

SOMA 350MG #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Carisoprodol Page(s): 65.

Decision rationale: As noted on page 65 of the Chronic Pain Medical Treatment Guidelines, Soma is not recommended for long-term use. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. The documentation indicates that the patient is being prescribed the medication for chronic pain and long-term care exceeding the recommended treatment window. However, abrupt cessation of this medication can be harmful and requires a slow taper over 2-4 weeks. As such, the medication is necessary.

NORCO 10/325MG #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Opioids, criteria for use Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. The injured worker is to be scheduled for rotator cuff repair which will require additional post-operative pain management to facilitate appropriate healing and rehabilitation. As such, the request for Norco 10/325 milligrams #30 is recommended as medically necessary with ongoing reevaluation of efficacy and intent to taper.

ULTRACET 325MG #50: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Opioids, criteria for use Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. The injured worker is to be scheduled for rotator cuff repair which will require additional post-operative pain management to facilitate appropriate healing and rehabilitation. As such, the request for Ultracet 325 milligrams #50 is recommended as medically necessary with ongoing reevaluation of efficacy and intent to taper.

MENTHODERM GEL 120GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Topical analgesics Page(s): 111.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore Menthoderm Gel 120 grams cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

FLURBIPROFEN 20% GEL 120GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Topical analgesics Page(s): 111.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore Flurbiprofen 20% Gel 120 grams cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

