MAXIMUS Federal Services

Case Number:	CM14-0017614		
Date Assigned:	02/24/2014	Date of Injury:	11/08/2011
Decision Date:	08/06/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	01/31/2014

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 Occupational Medicine 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 patient is a 53-year-old female who has submitted a claim for status post right shoulder arthroscopy with adhesive capsulitis, cervical spine strain/sprain, right wrist tendonitis, and cervicogenic headache, associated with an industrial injury date of November 8, 2011. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of right shoulder pain and swelling. She also complained of neck pain and numbness and tingling of the right upper extremity. On physical examination, her body mass index (BMI) was 38. There was spasm of the right upper trapezius muscle and there was tenderness of the right shoulder. Right shoulder range of motion was restricted on all planes with swelling over the anterior shoulder. Examination of the cervical spine revealed spasm. Distraction test caused neck pain. Treatment to date has included right shoulder arthroscopic subacromial decompression with distal clavicle resection (performed August 7, 2013), continuous passive motion (CPM) machine, 18 post-operative physical therapy sessions, and medications including Percocet 7.5 one tablet two times per day(BID) for pain (since at least August 2013). Utilization review from January 30, 2014 denied the request for physiotherapy, eight sessions (2x4) because the outcome of the concurrently requested acupuncture should first be assessed prior to consideration of additional therapy for which scope, nature, and outcome of prior treatment was not specified; and [redacted], ten weeks because the recent update did not specify the patient's weight or BMI to address the necessity of a weight loss program. The same utilization review modified the request for Percocet to Percocet 5/325 #20 to avoid withdrawal symptoms and allow for weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSIOTHERAPY; 8 SESSIONS (2 TIMES 4): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: According to the Post-Surgical Treatment Guidelines, a total of 24 visits over 14 weeks is supported for post-surgical treatment of patients who underwent arthroscopic repair of rotator cuff syndrome/impingement syndrome. In this case, the patient underwent right shoulder arthroscopic subacromial decompression with distal clavicle resection for impingement syndrome last August 7, 2013 and had 18 post-operative physical therapy sessions to date. Additional post-operative physical therapy sessions were requested to increase range of motion and decrease pain. However, the present request is for eight additional sessions. The approval of which will exceed the recommended total number of post-operative physical therapy visits, which is 24 sessions. A rationale regarding the excess therapy visits was not provided. Furthermore, the present written request failed to specify the body part to be subjected to physical therapy. Therefore, the request for physiotherapy for 8 sessions (2 times per week for 4 weeks) is not medically necessary.

[redacted]; 10 WEEKS: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CMS-40.5- Treatment of Obesity (Rev. 54, Issued: 04-28-06, Effective: 02/21/06, Implementation: 05/30/06 Carrier/10-02-06 Fl).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Tsai, AG and Wadden, TA. (2005). Evaluation of the major commercial weight loss programs. Annals of Internal Medicine, 142: 1-42; Aetna Clinical Policy Bulletin: Weight Reduction Medications and Programs.

Decision rationale: CA MTUS does not specifically address weight loss programs. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Annals of Internal Medicine and Aetna Clinical Policy Bulletin was used instead. Guidelines state that physician supervised weight loss programs are reasonable in patients who have a documented history of failure to maintain their weight at 20% or less above ideal or at or below a body mass index (BMI) of 27 when the following criteria are met: BMI greater than or equal to 30 kg/m2; or a BMI greater than or equal to 27 and less than 30 kg/m2 with one or more of the following comorbid conditions: coronary artery disease, diabetes mellitus type 2, hypertension, obesity-hypoventilation syndrome, obstructive sleep apnea or dyslipidemia. In this case, records showed that the patient's BMI was 38 kg/m2. The criteria were met. Therefore, the request for [redacted] for 10 weeks is medically necessary.

PERCOCET: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Specific Drug List) Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (On-going Management) Page(s): 78-81.

Decision rationale: According to pages 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, ongoing opioid treatment is not supported unless prescribed at the lowest possible dose and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, Percocet was being prescribed since at least August 2013 (11 months to date). However, given the 2011 date of injury, the exact duration of opioid use is not clear. In addition, there was no discussion regarding non-opiate means of pain control or endpoints of treatment. The records also do not clearly reflect continued analgesia or functional benefit or a lack of adverse side effects or aberrant behavior. Furthermore, the present written request failed to specify the frequency and duration of use, and quantity of drug to be dispensed. Although opioids may be appropriate, additional information would be necessary, as CA MTUS require clear and concise documentation for ongoing opioid management. Therefore, the request for Percocet is not medically necessary.