MAXIMUS Federal Services

Case Number:	CM14-0110828		
Date Assigned:	09/16/2014	Date of Injury:	11/29/2013
Decision Date:	10/17/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	07/16/2014

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 Physical Medicine and Rehabilitation 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 53-year-old male with a reported date of injury on 11/29/2013. The injury reportedly occurred when the injured worker was assaulted by a customer. His diagnoses were noted to include status post fracture/dislocation of the left 4th and 5th fingers, left ring finger severe flexion contracture to the interphalangeal proximal joint with boutonniere deformity, left little finger moderate flexion contracture to the interphalangeal proximal joint - 5 with boutonniere deformity and left ulnar neuropathy with intrinsic weakness. His previous treatments were noted to include occupational therapy, splinting and medications. The ultrasound report dated 05/28/2014 revealed left calcific rotator cuff tendinosis, left acromial joint hypertrophy/osteophyte formation/narrowing of the subacromial space, left anterior superior glenoid labral degeneration, and left normal long head biceps tendon. The progress note dated 06/16/2014 revealed complaints of left shoulder that failed to improve with conservative treatment. The injured worker revealed he had completed some conservative treatment to the lumbar spine and left shoulder which helped mainly in decreasing lumbar spine symptoms. The injured worker complained of left shoulder pain with decreased range of motion. The injured worker complained of difficulty with activities of daily living such as grooming and getting dressed and revealed he had completed a diagnostic ultrasound study and wished to proceed with invasive treatment since his symptoms had not improved with conservative care. The provider indicated an ultrasound study performed 05/28/2014 revealed left shoulder calcific rotator cuff tendonitis, acromioclavicular degenerative joint disease, subacromial narrowing and labral degeneration. The physical examination of the left shoulder revealed tenderness to palpation over the subacromial region, acromioclavicular joint and supraspinatus tendon. The impingement test and cross arm test were positive and the range of motion of the left shoulder was diminished. The injured worker indicated with pain medications his pain level was rated

3/10 and without medications rated 6/10. The injured worker indicated with medications he was able to perform activities of daily living, improve participation in the home exercise program, and improve his sleep pattern. The progress note dated 08/04/2014 revealed the injured worker revealed 60% improvement of the lumbar spine with physical therapy. The injured worker indicated he was able to walk his dog and pull trash cans at home but still had ongoing left shoulder symptoms. The physical examination of the left shoulder revealed tenderness to palpation over the subacromial region, supraspinatus tendon, and acromioclavicular joint. The impingement test and cross arm test were positive and there was still decreased active range of motion. There was severe pain greater than 90 degrees upon flexion and abduction. The provider indicated the injured worker was to proceed with a left shoulder subacromial injection that was authorized. The request for authorization form dated 06/16/2014 was for shockwave therapy for the left shoulder (3 treatments) for pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #60: Upheld

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

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

Decision rationale: The request for Norco 5/325 mg #60 is not medically necessary. The injured worker has been utilizing this medication since at least 01/2014. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state the "4 A's" for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors, should be addressed. The injured worker indicated that with pain medications his pain went down to 3/10 and without medications his pain was at 6/10 and with medications he was able to perform activities of daily living, participate in a home exercise program and improve his sleep pattern. There is lack of documentation regarding side effects and without details regarding urine drug screens consistent urine drug screens and when the last test was performed, the ongoing use of opioid medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Shockwave Therapy to left shoulder (3 treatments): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, EWST.

Decision rationale: The request for shockwave therapy to left shoulder (3 treatments) is not medically necessary. The injured worker complained of decreased range of motion and ongoing pain to the left shoulder. The Official Disability Guidelines recommend extracorporeal shockwave therapy for calcifying tendonitis but not for other shoulder disorders. The guidelines criteria for the use of extracorporeal shockwave therapy is for patients whose pain from calcifying tendonitis of the shoulder has remained despite 6 months of standard treatment. At least 3 conservative treatments have been performed prior to the use of ESWT which would include rest, ice, NSAIDs, orthotics, physical therapy, and injections. The guidelines contraindicate extracorporeal shockwave therapy in injured workers who received a local steroid injection within the past 6 weeks, injured workers with bilateral pain and injured workers who had previous surgery for the condition. The guidelines recommend a maximum of 3 therapy sessions over 3 weeks. The injured worker has been diagnosed with calcifying tendonitis of the shoulder of the rotator cuff; however, there is a lack of documentation regarding 3 specific conservative treatments that have been performed and failed. The documentation provided indicated the injured worker had some conservative treatment of the shoulder and the last progress note revealed authorization for a cortisone injection; however, there is a lack of documentation regarding as to whether the injured worker received it or not and the efficacy. Therefore, the request is not medically necessary.