

Case Number:	CM14-0026556		
Date Assigned:	06/13/2014	Date of Injury:	04/27/2010
Decision Date:	07/17/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/22/2014

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, has a subspecialty in Interventional Spine, 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 62-year-old male with a date of injury of 04/27/2010. The listed diagnoses per the provider are: cervical, thoracic, lumbar spine right radiculitis, bilateral shoulder sprain/strain right side impingement, bilateral knee sprain, history of inguinal hernia, and right leg radiculitis. This patient is status post arthroscopic left shoulder rotator cuff repair on 10/02/2013. The patient's treatment history includes physical therapy, medication, activity modification, and electrical stimulation. According to progress report 01/10/2014, the patient reported good pain control with medicine with pain level at 8/10 before medication and 4/10 after medication. It was noted the patient is participating in physical therapy. Physical examination of the lumbar spine revealed guarding of the bilateral paravertebral muscle. There was asymmetric motion loss. Examination of the left shoulder revealed some tenderness. Range of motion of the shoulder was 170 degrees at flexion, 40 degrees at extension, 160 degrees at abduction, 40 degrees at adduction, and the internal rotation at 80 degrees and external rotation at 70 degrees. The treatment plan included refill of Norco #60, continue home care assistant 4 hours per day once a week for 6 weeks, and physical therapy 1 x 4. A utilization review denied the requests on 01/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

PT (PHYSICAL THERAPY) 1X4 (UNSPECIFIED BODY PART): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back, Low back - Lumbar & Thoracic (acute & chronic), Shoulder, Knee & Leg: Physical therapy.

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

Decision rationale: This patient is status post arthroscopic left shoulder rotator cuff repair on 10/02/2013. The treating physician is requesting additional physical therapy one (1) time per week for four (4) weeks. The medical records indicate the patient received 12 post operative physical therapy. The outcomes produced by these sessions are unclear as there are no physical therapy progress reports provided for review. On 11/26/2013, the treating physician noted healed scar and some residual tenderness and recommended continuation of home exercise program. Following progress report 01/10/2014 documented continued decreased range of motion and tenderness and request was for one (1) time per week for four (4) weeks physical therapy (PT). The utilization review denied the request stating "injuries occurred in 2010 and he has been described as having chronic pain and arthritis with no new injury of surgery there is no necessity to continue PT." The MTUS postsurgical guidelines indicate that treatment for arthroscopic are 24 visits over 14 weeks and postsurgical physical medicine treatment period for 6 months. This patient has only had 12 post-operative therapy and continues to have residual tenderness. A short course of 4 sessions to address these issues is reasonable. Thus, the recommendation is for approval.

CONTINUED HOME CARE FOUR (4) HOURS/DAY FOR ONE (1) DAY A WEEK X SIX (6) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: This patient is status post arthroscopic left shoulder rotator cuff repair on 10/02/2013. The medical records indicate the patient received home care assistant following his shoulder surgery for 16 hours per day for one week then eight hours per day for seven days. The treating physician is requesting continuation of home care assistant four hours a day at one time a week for six weeks. The MTUS guidelines has the following regarding home services, "Recommended only for otherwise recommended medical treatment for patients who are homebound on a part-time or intermittent basis generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." While this patient is status post left shoulder surgery from 10/02/2013, the progress reports provided do not discuss whether this patient is immobilized or homebound. Furthermore, the progress reports from following the surgery only note tenderness and decrease range of motion. Thus, the recommendation is for denial.

NORCO 10/325MG, # 60 PRESCRIBED ON 1/10/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, long-term assessment Page(s): 88-89.

Decision rationale: This patient is status post arthroscopic left shoulder rotator cuff repair on 10/02/2013. The treating physician is requesting refill of Norco 10/325 mg #60. The MTUS guidelines require "Pain Assessment" that should include, "current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." Furthermore, "The 4 A's for ongoing monitoring" are required that include analgesia, activities of daily living (ADLs), adverse side effects and aberrant drug-seeking behavior. This patient has been taking Norco prior to surgery and post operatively. In reviewing the reports from 07/18/2013 to 01/10/2014, the treating physician does note a decrease in pain using a pain scale in one report but provides no discussion of specific functional improvement in any of his report, as required by the MTUS guidelines. Given the lack of sufficient documentation, the patient should slowly be weaned off of Norco as outlined in the MTUS Guidelines. Furthermore, the patient has been taking Norco since at least 07/18/2013 and there is no urine drug screen provided for the monitoring of this patient's medication compliance. The recommendation is for denial.