MAXIMUS Federal Services

Case Number:	CM14-0182773		
Date Assigned:	11/18/2014	Date of Injury:	03/21/2012
Decision Date:	01/06/2015	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	11/03/2014

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:

This is a 43 year old female with a 3/21/12 injury date. A 3/30/14 right shoulder MRI revealed rotator cuff tendinosis and acromioclavicular (AC) joint arthrosis. In a 9/9/14 note, the patient complained of 8/10 pain in the right shoulder that was worse with overhead use and lifting. Objective findings included positive impingement signs, positive AC joint tenderness, positive AC joint compression test, and positive cross-over test. Resisted abduction strength was 4/5 and external rotation strength was 4/5. Range of motion was painful but nearly normal. Multiple previous clinical notes were reviewed which demonstrated evidence of previous cortisone injections to the right shoulder with only temporary relief. There was previous approval of Diclofenac for post-op use after the procedure. Diagnostic impression: right shoulder impingement syndrome, AC joint arthritis. Treatment to date: Physical Therapy, Injections, Medications. A UR decision on 10/3/14 denied the request for right shoulder arthroscopy with subacromial decompression and Mumford because there was no documentation of a subacromial or AC joint steroid injection. The requests for Vascutherm, physical therapy, Ondansetron, Tramadol ER, Cyclobenzaprine, and Omeprazole were denied because the associated surgical procedure was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy (subacromial decompression, AC joint resection): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Surgery for Impingement syndrome, Mumford.

Decision rationale: CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. ODG supports partial claviculectomy (including Mumford procedure) with imaging evidence of significant AC joint degeneration along with physical findings (including focal tenderness at the AC joint, cross body adduction test, active compression test, and pain reproduced at the AC joint with the arm in maximal internal rotation may be the most sensitive tests), and pain relief obtained with an injection of anesthetic for diagnostic purposes. Non-surgical modalities includes at least 6 weeks of care directed towards symptom relief prior to surgery including anti-inflammatories and analgesics, local modalities such as moist heat, ice, or ultrasound. In this case, the documentation fulfills the criteria for the procedure. There was objective clinical and imaging evidence to support a diagnosis of both impingement syndrome and AC joint arthritis. In addition, there was a failure of appropriate conservative treatment including physical therapy, medications, and cortisone injections. Therefore, the request for right shoulder arthroscopy (subacromial decompression, AC joint resection) is medically necessary.

Associated Surgical Service: VascuTherm 4 with DVT Cold Compression Device (21-day rental): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee Chapter--Continuous-flow cryotherapy.

Decision rationale: CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, the guideline criteria do not support a 21 day rental of a cold therapy unit. Therefore, the request for VascuTherm 4 with DVT Cold Compression Device (21-day rental) is not medically necessary.

Associated Surgical Service: Post-Operative Physical Therapy (18-sessions, 3 times per week for 6 weeks, for the right shoulder): Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: CA MTUS supports 24 physical therapy sessions over 14 weeks after arthroscopic subacromial decompression surgery. The current request for 18 sessions over 6 weeks is appropriate and supported by the guidelines. Therefore, the request for post-operative physical therapy (18-sessions, 3 times per week for 6 weeks, for the right shoulder) is medically necessary.

Retrospective request for Ondansetron (4mg, #60, DOS: 9/9/2014): Overturned

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

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: FDA (Ondansetron).

Decision rationale: CA MTUS does not address this issue. The FDA states that Ondansetron is indicated for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. Given the approval of the associated surgery and the possibility for post-op nausea, the request for Zofran is supported. Therefore, the request for retrospective request for Ondansetron (4mg, #60, DOS: 9/9/2014) is medically necessary.

Retrospective request for Tramadol ER (150mg, #60, DOS: 9/9/2014): Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48,Chronic Pain Treatment Guidelines Page(s): 79-81.

Decision rationale: CA MTUS states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time, such as in a postoperative setting. Given the certification of the associated procedure and the need for post-op pain control, the request for tramadol is supported. Therefore, the request for retrospective request for Tramadol ER (150mg, #60, DOS: 9/9/2014) is medically necessary.

Retrospective request for Cyclobenzaprine (7.5mg, #90, DOS: 9/9/2014): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 41-42.

Decision rationale: According to page 41 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended. Given the certification of the associated procedure and the post-op use of this medication, the request is supported. Therefore, the request for retrospective request for Cyclobenzaprine (7.5mg, #90, DOS: 9/9/2014) is medically necessary.

Retrospective request for Omeprazole (20mg, #60, DOS: 9/9/2014): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI Symptoms and Cardiovascular Risk. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Omeprazole).

Decision rationale: CA MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as; gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. Omeprazole is a proton pump inhibitor, PPI, used in treating reflux esophagitis and peptic ulcer disease. Given the approval of the associated surgery and the concurrent post-op use of the NSAID Diclofenac, the use of Omeprazole for GI prophylaxis is supported. Therefore, the request for retrospective request for Omeprazole (20mg, #60, DOS: 9/9/2014) is medically necessary.