

Case Number:	CM14-0199258		
Date Assigned:	12/09/2014	Date of Injury:	01/24/2011
Decision Date:	01/26/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/26/2014

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 Hawaii, Washington and Maryland. 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 55-year-old male who reported an injury on 01/24/2011 due to strenuous activities at work. His diagnoses were noted to include persistent symptomatic left shoulder impingement syndrome and distal clavicle arthrosis. His past treatments were noted to include medications including anti-inflammatories, chiropractic therapy, physical therapy, subacromial cortisone injections, psychiatric evaluations, medial branch nerve blocks, acupuncture, and qualitative Functional Capacity Evaluation dated 10/02/2014. His diagnostic studies were noted to include EMG to bilateral upper extremity on 08/27/2012, MRI of the right knee dated 09/10/2013, and x-rays. His surgeries were noted to include radiofrequency ablation at C4-5 and C5-6, right shoulder arthroscopic subacromial decompression dated 12/16/2013, left knee arthroscopic microfracture and meniscectomy dated 07/15/2014, arthroscopic repair of superior labral SLAP tear of the left shoulder, arthroscopic debridement of glenohumeral joint with debridement of rotator cuff and posterior labral tear, acromioplasty and resection of the coracoacromial ligament and subacromial bursa to the left shoulder, and arthroscopic resection and distal clavicle of the left shoulder on 12/02/2014. On 11/28/2014, the injured worker complained of pain to his cervical spine, right wrist and bilateral knees. He rated his pain 7/10. The documentation submitted for review was hand written and not easy to decipher. On 12/01/2014, the injured worker was noted to continue to have persistent moderate left shoulder pain aggravated by attempted lifting, reaching, and pushing activities. The physical examination of the left shoulder noted range of motion as forward flexion to the right 180 degrees and to the left 150 degrees, abduction to the right was 180 degrees and to the left 150 degrees, external rotation in abduction 90 degrees to the right and 70 degrees to the left, external rotation at side was noted as 60 degrees to the right and 70 degrees to the left, and internal rotation behind back was noted T8 to the right and T10 to the left. The documentation noted a negative O'Brien's test

to the right and left. The injured worker was noted to have a Neer's impingement test positive to the left, a Hawkins' impingement test also positive to the left, and Jobe's test with pain with resisted abduction positive to the left. There was also noted tenderness to the acromioclavicular joint to the left with a positive anterior AC joint stress test and posterior AC joint stress test to the left. Motor strength was noted as forward flexion to the right was 5 and to the left was also 5, abduction to the right was 5 and to the left was 4, external rotation was noted at 5 and left was noted at 4, and internal rotation was noted at 5 and to the left was noted as 5. Lift off test was 5 bilaterally. The right shoulder and left shoulder noted normal sensation and reflexes. The injured worker's medications were noted to include Norco and Omeprazole and cyclobenzaprine. The provider's treatment plan was noted for the injured worker to continue with medication regimen and surgery as planned. The rationale for the requested treatments and the Request for Authorization were not included in the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Weaning of Medications Page(s): 78-80,.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco, Page(s): 78, 98.

Decision rationale: The California MTUS Guidelines state the usual dose of Norco is 5/500 mg 1 tablet to 2 tablets by mouth every 4 hours to 6 hours as needed for pain for a maximum of 8 tablets a day. The guidelines also state prescriptions should be from a single practitioner and taken as directed, and all prescriptions from a single pharmacy. The lowest dose possible should be prescribed to improve pain and function. The MTUS Guidelines also state there should be an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include the current pain, least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control is recommended. Given the above guidelines, the injured worker is not within the California MTUS Guidelines. There are no side effects listed in the submitted reports. There is also no evidence that Norco was helping with any of the functional deficits the injured worker had. The documentation submitted for review failed to include objective documentation of pain relief with subjective functional improvement. Furthermore, a drug screen submitted on 08/07/2014 showed an inconsistent drug screen based on prescription therapy provided. Additionally, the request submitted also failed to provide a frequency and the quantity of the medication. As such, the request for Norco 10mg #60 is not medically necessary.

Cyclobenzaprine cream 240mg with 1 refill: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that transdermal compounds are experimental in use with few randomized controlled trials to determine efficiency or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines note muscle relaxants are not recommended for topical application. As the guidelines do not recommend the use of muscle relaxants for topical application, this medication would not be indicated. Therefore, the request is not indicated at this time. As such, the request for Cyclobenzaprine cream 240mg with 1 refill is not medically necessary.

Post-Operative Physical Therapy 3 times a week for 4 weeks for the Bilateral Knees:
Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: The postsurgical guidelines recommend physical therapy 12 visits over 12 weeks for 6 months for a Meniscectomy. In the documentation submitted for review it was unclear how many post physical therapy sessions the injured worker had completed if any as well as lack of documentation of the efficacy of the prior therapy sessions to warrant the request. Additionally, the documentation submitted for review did not indicate the injured worker was active in a home exercise program. Therefore, the request for Post-operative physical therapy 3 times a week for 4 weeks for the bilateral knees is not indicated at this time. As such, the request for Post-Operative Physical Therapy 3 times a week for 4 weeks for the Bilateral Knees is not medically necessary.

MRI (Magnetic Resonance Imaging) of the Right Wrist: 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), Forearm, Wrist & Hand, MRI's (Magnetic Resonance Imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The California MTUS/ACOEM Guidelines state, for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4 week

to 6 week period of conservative care and observation, and red flag conditions are ruled out. The guidelines state an acute injury to the metacarpophalangeal joint of the thumb, accompanied by tenderness on the ulnar side of the joint and laxity when that side of the joint is stressed compared to the other side, may indicate a gamekeeper thumb or rupture of the ligament at that location. Radiographic films may show a fracture; stress views, if obtainable, may show laxity. The diagnosis may necessitate surgical repair of the ligament; therefore, surgical referral is warranted. In the documentation submitted for review, the injured worker stated the left wrist was doing well and the right wrist MRI was reviewed, and the documentation states the provider will schedule a right LMC injection in 6 weeks to 8 weeks. However, there was a lack of documentation providing progressive neurological deficits, new findings suggestive of pathology that does not correlate with the last MRI, and lack of documentation stating the injured worker has failed conservative care for at least a 4 week to 6 week period. As such, the request for MRI (Magnetic Resonance Imaging) of the right wrist is not medically necessary.

Transportation to and from all office visits: 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), Knee & Leg, Transportation (to and from appointments).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Transportation (to & from appointments).

Decision rationale: The Official Disability Guidelines state transportation to and from appointments is recommended for medically necessary transportation to appointments in the same community for patients with disabilities preventing them from self transport. This reference applies to patients with disabilities preventing them from self transportation who of age of 55 or older and need a nursing home level of care. Transportation in other cases should be agreed upon by the payor, provider, and patient as there is limited scientific evidence to direct practice. In the documentation submitted for review, there was no evidence stating the injured worker had a disability preventing them from self transportation. As such, the request for Transportation to and from all office visits is not medically necessary.