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| Case Number: | CM14-0208724 | | |
| Date Assigned: | 02/02/2015 | Date of Injury: | 07/20/2012 |
| Decision Date: | 04/03/2015 | UR Denial Date: | 12/05/2014 |
| Priority: | Standard | Application Received: | 12/12/2014 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Orthopedic Surgery

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 56-year-old female, who sustained an industrial injury on 7/12/2012. The diagnoses have included discogenic cervical condition with magnetic resonance imaging (MRI) showing disc disease from C3 through C7, impingement syndrome of the shoulder on the right with MRI showing bursitis, labral tear and acromioclavicular (AC) joint wear, impingement of the shoulder on the left with MRI showing moderate tear of the rotator cuff, AC joint wear and labral tear and depression and sleep disorder due to chronic pain. Treatment to date has included chiropractic treatments, shoulder injection and pain medications. According to the evaluation dated 11/7/2014, the injured worker complained of pain in the neck, both shoulders and right wrist. Objective findings included tenderness along the rotator cuff and to a lesser extent the biceps tendon. There was tenderness along the posterior capsule. There were findings of impingement. Authorization was requested for right shoulder surgery and related services. On 15/5/2014, Utilization Review (UR) non-certified a request for Right shoulder arthroscopy-decompression and right shoulder evaluation of biceps tendon and repair of labrum, citing Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) and Official Disability Guidelines (ODG). UR non-certified requests for Left shoulder subacromial space injection and Left shoulder fluoroscopic evaluation citing MTUS, ACOEM and ODG. UR non-certified a request for Nalfon 400mg #60, citing MTUS guidelines. UR modified a request for Flexeril 7.5mg #60 and Lunesta 2mg #30 to allow for the potential of weaning, citing MTUS and ODG. UR non-certified requests for Polar care - 21 days, Shoulder immobilizer, Amoxicillin 875mg #20, Zofran 8mg #20, Topamax 50mg #120,

Pre-operative clearance history and physical, Pre-operative tests: complete blood count and comprehensive metabolic profile (CMP), Pre-operative electrocardiogram, Preoperative chest x-ray and Amox-Clavulanate (Augmentin) 875/125 #20 due to the surgery not being medically necessary at this time. UR modified a request for Ultracet 37.5mg #60 (retrospective) to allow for the potential of weaning citing MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy - decompression, evaluation of biceps tendon, and repair of labrum: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Acromioplasty surgery.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from .11/7/14 In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 11/7/14 does not demonstrate evidence satisfying the above criteria except. Therefore, the request is not medically necessary.

Left Shoulder Subacromial Space Injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: According to CA MTUS/ACOEM guidelines 2nd edition, Chapter 9, Shoulder complaints, page 204, Initial care, subacromial injection may be indicated after conservative therapy for two to three weeks. In this case, the exam note from 11/7/14 does not indicate if conservative care has been attempted and failed. Therefore, the request is not medically necessary.

Left Shoulder Fluoroscopic Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Nalfon 400mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nalfon Page(s): 71.

Decision rationale: Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 71 states that Nalfon (Fenopropfen) is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. There is lack of demonstration of functional improvement from the exam note from 11/7/14 or failure of first line analgesics. Therefore, the request is not medically necessary.

Flexeril 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41 and 64.

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

Decision rationale: According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42 "Recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended." In this particular case, the patient has no evidence in the records of 11/7/14 of functional improvement, a quantitative assessment on how this medication helps percentage of relief lasts, increase in function, or increase in activity. Chronic usage is not supported by the guidelines. Therefore, the request is not medically necessary.

Lunesta 2mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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, Mental Illness and stress, Eszopicolone (Lunesta).

Decision rationale: CA MTUS/ACOEM is silent on the issue of Lunesta. According to the ODG, Mental illness and stress chapter, Lunesta is, "Recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers." In this case, there is lack of documentation from the exam note of 11/7/14 of insomnia to support Lunesta. Therefore, the request is not medically necessary.

Associated Surgical Services: Polar Care for 21 days: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Services: Shoulder Immobilizer: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Amoxicillin 875mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Stulberg DL, Penrod MA, Blatny RA. Common bacterial skin infections. Am Fam Physician. 2002 Jul 1; 66(1):119-24.

Decision rationale: CA MTUS/ACOEM and ODG are silent on the issue of Keflex, therefore alternative guideline was utilized. According to the American Family Physician Journal, 2002 July 1; 66 (1): 119-125, titled "Common Bacterial Skin Infections"; Keflex is often the drug of choice for skin wounds and skin infections. There is no evidence from the records of 11/7/14 of a

wound infection to warrant antibiotic prophylaxis. Therefore, the request is not medically necessary.

Zofran 8mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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) Pain, Ondansetron.

Decision rationale: CA MTUS/ACOEM is silent on the issue of Zofran for postoperative use. According to the ODG, Pain Chapter, Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use." In this case the exam note of 11/7/14 demonstrates no evidence of nausea and vomiting or increased risk for postoperative issues. Therefore, the request is not medically necessary.

Topamax 50mg #120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate Page(s): 21.

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines page 21, Specific Anti-Epilepsy Drugs, Topiramate is indicated for neuropathic pain of central etiology and when other anticonvulsants fail. In this case, the exam note from 11/7/14 does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. There is no documentation of failed first line anti-epilepsy drugs such as Neurontin. Therefore, the request is not medically necessary.

Pre-Operative Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-Operative Tests: CBC and CMP: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-Operative EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-op chest x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.