

Case Number:	CM15-0107745		
Date Assigned:	06/12/2015	Date of Injury:	09/25/2013
Decision Date:	08/31/2015	UR Denial Date:	05/07/2015
Priority:	Standard	Application Received:	06/04/2015

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, Indiana, Oregon

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 was a 50 year old female, who sustained an industrial injury, September 25, 2013. The injury was sustained when the injured worker was picking olives and fell from the ladder and landing on her back. The injured worker previously received the following treatments physical therapy for the back, Brain MRI, right knee MRI on November 12, 2014, right shoulder MRI November 11, 2014, Naproxen, Amitriptyline, Prilosec, TENS (transcutaneous electrical nerve stimulator) unit, laboratory studies on December 1, 2014, CBC, Chemistries and urine analysis were within normal limits. The injured worker was diagnosed with subdural hematoma, multiple rib fractures on the left and right, fracture of proxima manubrium, traumatic brain injury in the falcine area, post-traumatic headaches, upper thoracic pain, sternal contusion, right knee pain, anxiety disorder, cognitive dysfunction, right shoulder bursitis and impingement, lumbar radiculopathy, lumbago, cervical radiculopathy, right shoulder AC joint arthritis, right shoulder rotator cuff arthropathy and right knee osteoarthritis. According to progress note of April 15, 2015, the injured workers chief complaint was right shoulder and right knee pain. The injured worker reported the right shoulder pain radiated into the hand and into the shoulder blade. The injured worker described the pain as constant. The injured worker rated the pain at 8 out of 10. The injured worker reported limitations in activities as the arm feels fatigued. The pain was primarily in the anterior. The pain was aggravated by lifting and over the head movement. There was decreased range of motion. There was tenderness over the biceps and pain with range of motion. There was joint stability and tracks well with range of motion. There was no instability with manipulation or weight bearing. The Neer's test, Hawkin's test, Yergason's test Speed test,

O'Brien's test were all positive. There was decrease sensation at the C5, C6 C7, and C8 dermatomes. The treatment plan included right shoulder arthroscopic surgery, preoperative medical clearance, per-operative chest x-ray, EKG (Electrocardiography), CBC, (complete blood cell count), PT (prothrombin time), PTT (partial thrombin time), INR, postoperative physical therapy, and prescriptions for Percocet, Keflex, Ambien and Zoran.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with subacromial decompression distal clavicle resection:

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, Shoulder: Surgery for Impingement Syndrome (4/3/15).

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

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. 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 4/15/15 does not demonstrate evidence satisfying the above criteria notably the weak or absent abduction. Therefore the request does not adhere to guideline recommendations and is not medically necessary

Preoperative medical 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.

Preoperative 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.

12 Postoperative Physical Therapy sessions for the right shoulder: 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.

1 prescription of Percocet 10/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 4/15/15. Therefore the request is not medically necessary.

1 prescription of Keflex 500mg #12: Upheld

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

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 FamPhysician. 2002 Jul 1; 66(1): 119-24.

Decision rationale: CA MTUS/ACOEM and ODG are silent on the issue of Keflex and 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. It was found from a review of the medical record submitted of no evidence of a wound infection to warrant antibiotic prophylaxis. The request for Keflex is therefore not medically necessary and appropriate.

1 prescription of Ambien 10mg #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 (ODG) pain.

Decision rationale: CA MTUS/ACOEM is silent on the issue of Ambien. According to the ODG, Pain Section, Zolpidem (Ambien) is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. 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. There is also concern that they may increase pain and depression over the long-term. There is no evidence in the records from 4/15/15 of insomnia to warrant Ambien. Therefore the request is not medically necessary.

1 prescription of Zofran 4mg #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 (ODG) pain.

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 submitted records demonstrate no evidence of nausea and vomiting or increased risk for postoperative issues. Therefore determination is not medically necessary.

Preoperative 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.

Preoperative CBC: 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.

Preoperative Chem 7: 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.

Preoperative PT/PTT/INR: 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.