MAXIMUS Federal Services

Case Number:	CM15-0193134		
Date Assigned:	10/07/2015	Date of Injury:	07/01/2005
Decision Date:	12/18/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	10/01/2015

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 is a 69 year old female, who sustained an industrial injury on July 1, 2005, incurring right shoulder neck and head injuries. She was diagnosed with right shoulder tendinopathy, degenerative joint disease and bursitis. Treatment included shoulder injections, pain medications, neuropathic medications, topical analgesic patches, sleep aides and activity restrictions. Currently, the injured worker complained of persistent right shoulder pain with loss of range of motion of her shoulder. She noted right shoulder pain radiating down into the right arm. She was unable to lift her right arm above her head or behind her back. The pain medications and patches were not helping with relief of the pain. Shoulder injections helped relieve her pain only for a short time. The shoulder revealed crepitus and diminished range of motion. She was diagnosed with increased impingement and capsulitis of the right shoulder. The treatment plan that was requested for authorization on October 1, 2015, included a right shoulder arthroscopic debridement and posterior capsular release (inspection of rotator cuff); twelve post-operative physical therapy sessions; preoperative CBC, CMP, urinalysis and electrocardiogram; and prescriptions for Percocet 10-325 mg #60, Tramadol 50mg #60, Lunesta 2 mg #45 and two boxes of Flector Patch. On August 24, 2015, these requests were denied and non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic extensive debridement and posterior capsular release (inspection of rotator cuff): Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

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: CA MTUS/ACOEM is silent on the issue of surgery for adhesive capsulitis. Per ODG shoulder section, the clinical course of this condition is self-limiting. There is insufficient literature to support capsular distention, arthroscopic lysis of adhesions/capsular release or manipulation under anesthesia (MUA). In this case, there is evidence of adhesive capsulitis. The requested procedure is not recommended by the guidelines and therefore is not medically necessary.

Pre-op testing: 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-op testing: UA: 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 testing: 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.

Post-op Percocet 10/325 mg #60: 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.

Tramadol 50 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence in the records of failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore use of Tramadol is not medically necessary.

Lunesta 2 mg #45: 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).

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

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 notes of insomnia to support Lunesta. Therefore the request is not medically necessary.

Flector Patch - 2 boxes: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, specific drug list & adverse effects.

Decision rationale: CA MTUS/ACOEM is silent on the issue of Flector patch which is topical Diclofenac. According to the ODG, Pain section, Diclofenac Topical, it is not recommended as a first line treatment but is recommended for patients at risk for GI events from oral NSAIDs. In this case the exam notes do not demonstrate prior adverse GI events or intolerance to NSAIDs. Given the lack of documentation of failure of oral NSAIDs or GI events, the determination is not medically necessary.

Post-op physical therapy - 12 sessions: 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.