MAXIMUS Federal Services

Case Number:	CM15-0044891		
Date Assigned:	04/08/2015	Date of Injury:	08/31/2012
Decision Date:	05/19/2015	UR Denial Date:	03/09/2015
Priority:	Standard	Application Received:	03/10/2015

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
Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 64-year-old male who reported injury on 08/31/2012. The mechanism of injury was a slip and fall. Prior therapies included physical therapy and a right shoulder injection. There was a Request for Authorization submitted for review for surgical intervention dated 01/29/2015. The documentation of 01/20/2015 revealed the injured worker had low back pain, cervical pain and thoracic pain as well as right shoulder pain and right elbow pain. The documentation indicated medication facilitated improved activities of daily living including grocery shopping, essential household duties and caring for himself. Without medications the injured worker had difficulty. The injured worker had improved range of motion and greater tolerance to exercise with medications. The injured worker's pain level was noted to range from 5/10 to 7/10. The documentation indicated that with tramadol ER the injured worker had a 4-point decrease in pain and an improvement in range of motion and exercise tolerance. With NSAIDS, the pain relief was noted to be 3 points. Regarding proton pump inhibitors, the injured worker was utilizing it 3 times a day and had a history of GI upset with NSAIDS. The current dosing assisted with the GI upset. The spasms were noted to be refractory to physical therapy, activity modification, stretching, TENS unit, home exercise, cold and heat and cyclobenzaprine at 3 times a day dosing resulted in significant diminution in spasms. The injured worker had an increased tolerance to exercise and recommended activity level and greater range of motion with less pain. The injured worker denied side effects. The objective examination revealed positive impingement signs and tenderness on the right shoulder. The right shoulder had flexion of 90 degrees, abduction 90 degrees, external rotation to 50 degrees and internal rotation to 50 degrees.

There was atrophy of the right deltoid musculature and swelling of the right shoulder. The diagnoses included right shoulder subacromial bursitis and impingement and lumbar myofascial pain. The treatment plan included a continued request for right shoulder arthroscopic subacromial decompression, continue follow-up with psychiatrist as it facilitated and diminished reactive depression and anxiety. There was a continued request for musculoskeletal tumor expert to evaluate the mass in the right paraspinal region to rule out or establish industrial causation. The treatment plan further indicated the injured worker would have a refill of medications. The documentation indicated the injured worker underwent an MRI of the right shoulder, which revealed extrinsic impingement of the traversing underlying supraspinatus on 09/25/2013. The injured worker was noted to be previously approved for a specialist evaluation for the mass in the right paraspinal region. The injured worker was noted to be authorized for right shoulder MRI on 02/04/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopic Subacromial Decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Shoulder Procedure Summary (updated 8/27/14).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have a failure to increase range of motion and strength of musculature in the shoulder after exercise programs and who have clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. For injured workers with a partial thickness or small full thickness tear, impingement surgery is reserved for cases failing conservative care therapy for 3 months and who have imaging evidence of rotator cuff deficit. For surgery for impingement syndrome, there should be documentation of conservative care including cortisone injections for 3 to 6 months before considering surgery. The clinical documentation submitted for review failed to provide documentation of specific conservative care and the duration of conservative care. There was a lack of documentation of MRI findings. No official MRI was submitted for review. Given the above, the request is not medically necessary.

Musculoskeletal Tumor Expert Evaluation: 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) Treatment in Workers Compensation (TWC); Pain Procedure Summary Online Version (updated 1/19/15), Office Visits.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The clinical documentation submitted for review indicated the injured worker had previously been authorized for the requested consult on 12/11/2014. There was a lack of documentation indicating if this was an additional consultation and the rationale for additional consultation. Given the above, the request is not medically necessary.

Pre-Operative Labs: CMP/eGFR, PT, UA/RflCul, CBC/diff, APTT, ABO/Rh, and 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.

Retro (DOS 1/20/15): Tramadol ER 150mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Ongoing Management Page(s): 60, 78.

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review met the above criteria. However, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request is not medically necessary.

Retro (DOS 1/20/15): Hydrocodone 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Ongoing Management Page(s): 60, 78.

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review met the above criteria. However, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request is not medically necessary.

Retro (1/20/15): Naproxen Sodium 550mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS guidelines indicate that NSAIDS are recommended for short-term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had objective functional benefit and an objective decrease in pain. However, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request is not medically necessary.

Retro (DOS 1/20/15): Pantoprazole 20mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California MTUS guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the injured worker previously had dyspepsia. The injured worker was noted to have benefit with the treatment of proton pump inhibitor 3 times per day. However, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request is not medically necessary.

Retro (DOS 1/20/15): Cyclobenzaprine 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Pain Procedure Summary (updated 1/19/15).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California MTUS guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had objective functional improvement with the use of the medication. However, the injured worker had utilized the medication for an extended duration of time. This medication would not be supported. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request is not medically necessary.

Continued Follow up with Psychiatrist: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Office Visit.

Decision rationale: The Official Disability Guidelines indicate the need for a clinical office visit with a health care provider is based on the injured worker's concerns, signs and symptoms, clinical stability, and physician judgment, as well as medications the injured worker is taking. The clinical documentation submitted for review indicated the request was made as the visits with the psychiatrist facilitated diminished reactive depression and anxiety. However, there was a lack of documentation of subjective functional improvement. The request as submitted failed to indicate the quantity of visits being requested. Given the above, the request is not medically necessary.

Urine Toxicology Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Pain Procedure Summary (updated 1/19/15) for Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: The California MTUS indicates that the use of urine drug screening is for injured workers with documented issues of abuse, addiction, or poor pain control. There was a lack of documentation indicating the injured worker had documented issues of addiction, abuse or poor pain control. Given the above, the request for urine toxicology screen is not medically necessary.