

Case Number:	CM15-0056788		
Date Assigned:	04/01/2015	Date of Injury:	08/01/2013
Decision Date:	05/18/2015	UR Denial Date:	03/07/2015
Priority:	Standard	Application Received:	03/25/2015

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: Nevada, California
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 41-year-old male who reported an injury on 06/01/2013. The diagnosis included sprain, rotator cuff. The injured worker was noted to be approved for surgical intervention for the shoulder. The mechanism of injury was not provided. The documentation of 02/23/2015 revealed the injured worker's surgery had been authorized. The injured worker was noted to have severe pain. The diagnoses included left shoulder partial rotator cuff tendon tear, low field magnet MRI; possible SLAP lesion; severe acromioclavicular joint arthritis; and worsening adhesive capsulitis. The treatment plan included an arthroscopy, rotator cuff repair, and a subacromial decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motrin 800mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201.

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 request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation of objective functional improvement and an objective decrease in pain. Given the above and the lack of documentation, the request for Motrin 800 mg #90 is not medically necessary.

Norco 10/325mg #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 failed to provide documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 10/325 mg #60 is not medically necessary.

Oxycontin 10mg #20: 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 failed to provide documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for OxyContin 10 mg #20 is not medically necessary.

Zofran 4mg #10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse.

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

Decision rationale: The Official Disability Guidelines indicate that antiemetics are not recommended for the treatment of nausea secondary to opioid therapy. They are, however, recommended for postoperative nausea and vomiting. The clinical documentation submitted for review failed to provide the rationale for the request. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Zofran 4 mg #10 is not medically necessary.

One cold therapy unit: 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 Official Disability Guidelines (ODG) Shoulder Chapter, Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines indicate that continuous flow cryotherapy is recommended for 7 days postoperatively. The clinical documentation submitted for review indicated the injured worker had been approved for surgical intervention. However, the request as submitted failed to indicate whether the unit was for rental or purchase. If the unit was for rental, the duration of use was not noted and there was a lack of documentation indicating the body part to be treated. Given the above, the request for 1 cold therapy unit is not medically necessary.

Keflex 500mg #15: 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) Infectious Disease Chapter, Cephalexin.

Decision rationale: The Official Disability Guidelines indicate that Keflex is recommended as a first line treatment for cellulitis and other conditions. The clinical documentation submitted for review indicated the injured worker would be undergoing surgical intervention, which would expose the injured worker to bacteria intraoperatively. However, the request as submitted failed to indicate the rationale and failed to indicate the frequency for the requested medication. Given the above, the request for Keflex 500 mg #15 is not medically necessary.