

Case Number:	CM14-0166307		
Date Assigned:	10/13/2014	Date of Injury:	12/19/2012
Decision Date:	11/13/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/09/2014

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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 52-year-old female insurance office manager sustained an industrial injury on 12/19/12. Injury occurred when her legs got caught under a reversing car. She was dragged for 50 feet, and run over at the knees. X-rays demonstrated no fractures. Injuries were reported to the both legs, head (scalp laceration), neck, back, and shoulders. She subsequently underwent right knee arthroscopy, lateral release, medial meniscectomy, medial capsular reconstruction and removal of loose bodies on 12/3/13, and left knee arthroscopy with partial medial and lateral meniscectomies, chondroplasty, and removal of loose bodies on 4/2/13. The 8/13/14 left shoulder MR arthrogram impression documented a tear of the superior labrum with a small paralabral cyst. There was no tear of the tendon attachment for the long head of the biceps. There were minimal degenerative changes of the greater tuberosity and mild acromioclavicular joint degenerative changes. The 8/13/14 cervical spine MRI impression documented multilevel disc bulges with no evidence of spinal stenosis or neuroforaminal narrowing at any level. The 8/13/14 lumbar spine MRI impression documented mild disc desiccation at L3/4 with 2 mm broad-based posterior disc bulge with right annular fissure, mild right facet degenerative changes, and no disc protrusion or extrusion, spinal stenosis, or neuroforaminal narrowing. At L4/5, there was mild bilateral facet degenerative changes with no disc protrusion or extrusion, spinal stenosis, or neuroforaminal narrowing. There was mild disc desiccation at L5/S1 with a 2 mm broad based disc bulge with mild degrees endplate changes and no central canal or neuroforaminal narrowing. The 8/19/14 bilateral lower extremity electrodiagnostic study documented evidence of chronic right S1 radiculopathy. The 9/8/14 treating physician report cited significant anterolateral left shoulder pain with popping and mild instability. She also complained of neck and back stiffness and spasms, and left arm numbness and tingling. She had shooting pain, numbness and tingling down both legs, right greater than left. Left shoulder exam documented loss of range of motion,

positive impingement signs, positive O'Brien testing, anterolateral tenderness, and popping with resisted forward flexion and abduction. Neck and back exam documented decreased range of motion, paraspinal spasms, no evidence of acute radiculopathy, and normal sensation and reflexes. The diagnosis was cervical sprain/strain with disc bulges, left shoulder impingement, right shoulder stiffness, lumbar sprain/strain with disc bulge, status post bilateral knee surgery with significant quadriceps weakness, and post-traumatic stress disorder. The treatment plan recommended spinal evaluation regarding the cervical and lumbar spine, left shoulder arthroscopy and associated durable medical equipment, medications, and pre-op evaluation by internal medicine, and updated urine toxicology tests. The 9/23/14 utilization review approved a request for left shoulder arthroscopy, subacromial decompression and labral repair, 12 post-op physical therapy visits, one cold therapy unit, post-op Vicodin 5/300 mg #60, and home exercise kit. The request for pre-op evaluation by an internal medicine specialist was denied as the medical necessity of a separate pre-op evaluation was not established. The request for an Ultra sling was denied as guideline criteria had not been met. The request for OxyContin was denied as there was no evidence that post-op Vicodin would be ineffective in managing the patient's pain. The referral for spine specialist evaluation for the cervical and lumbar spine was denied as there were no exam findings of neurologic deficits and inconsistent findings of radiculopathy. The request for a urine drug screen was denied as a previous urine drug screen was performed in June 2014 and there was no evidence of abuse or misuse.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 pre-op evaluation by an internal medicine specialist: Overturned

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 Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met for an internal medicine pre-op evaluation. Middle-aged overweight females have known occult increased medical/cardiac risk factors. Given these clinical indications, this request is medically necessary.

1 ultrasling: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. The Official Disability Guidelines state that post-op abduction pillow slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. This patient has a superior labral tear and arthroscopic repair is planned. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request is not medically necessary.

1 post-op prescription for Oxycontin 20 mg #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Oxycontin Page(s): 76-80, 97.

Decision rationale: The California MTUS guidelines indicate that OxyContin is a controlled release formulation of Oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. OxyContin is not indicated for use as an as needed analgesic. Guideline criteria have not been met. There is no indication that this patient would require around-the-clock analgesia for an extended period of time. A request for an as needed opioid medication has been found to be medically necessary. There is no compelling reason to support the medical necessity of an additional opioid for pain management. Therefore, this request is not medically necessary.

1 spine specialist evaluation for the cervical and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 180, 209, 202.

Decision rationale: The California MTUS guidelines state that referral for surgical consultation for the cervical spine is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms with activity limitation for more than one month or with extreme progression of symptoms. Criteria include documented failure of conservative treatment to resolve radicular symptoms and clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short- and long-term. The MTUS low back guidelines state that referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with

abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guideline criteria have not been met. Cervical and lumbar imaging documented disc bulging with no evidence of spinal stenosis or nerve root compression. The cervical and lumbar spine physical exam findings documented no evidence of acute radiculopathy or objective findings of nerve root compression. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the neck and back and failure has not been submitted. Therefore, this request is not medically necessary.

1 urine toxicology and confirmatory test: 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: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, Opioids-Criteria for use Page(s): 43, 76-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Urine drug testing (UDT)

Decision rationale: The California MTUS supports the use of urine drug screening in patients using opioid medication with issues of abuse, addiction, or poor pain control. The Official Disability Guidelines support on-going monitoring if the patient has evidence of high risk of addiction, history of aberrant behavior, history of addiction, or for evaluation of medication compliance and adherence. It is recommended that patients at low risk for adverse outcomes be monitored randomly approximately every 6 months. Guideline criteria have not been met. Records indicate that urine drug testing was performed on 6/2/14 with no documentation of inconsistencies. There is no evidence suggestive of issues of abuse, addiction, or poor pain control to support repeat testing at this time. Therefore, this request is not medically necessary.