

Case Number:	CM14-0210431		
Date Assigned:	12/23/2014	Date of Injury:	02/21/2012
Decision Date:	03/05/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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 52-year-old male who reported injury on 02/21/2012. The mechanism of injury was not submitted for review. The injured worker has diagnoses of cervical sprain/strain, lumbar radiculopathy, lumbar sprain/strain, rotator cuff syndrome, shoulder sprain/strain, knee sprain/strain, and insomnia. Past medical treatment consists of medication therapy. Medications consist of naproxen 550 mg and omeprazole 20 mg. No pertinent diagnostics were submitted for review. On 10/23/2014, the injured worker complained of right shoulder pain which he rated at an 8/10 and 7/10 with medication. Physical examination of the shoulder revealed tenderness noted upon palpation over the acromioclavicular joint, bicipital joint and post scapula. Medical treatment plan is for the injured worker to undergo right shoulder surgery. Rationale and Request for Authorization Form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Surgery: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 305-306.

Decision rationale: The request for Right Shoulder Surgery is not medically necessary. California MTUS/ACOEM Guidelines state, for surgical consideration there must be signs of severe disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, activity limitations due to radiating leg pain for more than 1 month and extreme progression of lower leg symptoms, clear clinical imaging and electrophysiologic evidence of a lesion that has been shown to be beneficial from the short and long term surgical repair, failure of conservative treatment and psychological screening. The submitted documentation indicated in the objective findings that the injured worker had tenderness upon palpation of the acromioclavicular joint and bicipital joint and post scapula. However, there was no diagnostic imaging submitted for review. There was no indication of the injured worker having trialed and failed conservative treatment. Additionally, there was no evidence submitted for review showing that the injured worker had undergone psychological screening. Given the above, the injured worker is not within guideline criteria. As such, the request is not medically necessary.

Multi-stim Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116,120,121. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Low Back

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121.

Decision rationale: The request for multi-stim unit is not medically necessary. The CA MTUS Guidelines state TENS is not recommended as a primary treatment modality. Interferential current stimulation is not recommended as an isolated intervention. Neuromuscular electrical stimulation is not recommended. In addition, the request does not indicate a duration of use or site of treatment. Therefore, the request is not medically necessary.

MRI of bilateral knees: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Knee

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

Decision rationale: The request for MRIs of the bilateral knees is not medically necessary. The CA MTUS/ACOEM Guidelines state reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. The examination of the knees

noted tenderness to palpation without swelling and decreased range of motion. There is no indication of any significant findings on examination to support the request. Therefore, the request is not medically necessary.

Urine Drug Test: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80 and 94. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: The request for urine drug test is not medically necessary. The CA MTUS Guidelines recommend drug testing as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. There is no indication the injured worker was misusing his medications or that the provider suspected him of misuse to warrant a urine drug screen. Therefore, the request is not medically necessary.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The request for Omeprazole is not medically necessary. The CA MTUS Guidelines recommend proton pump inhibitors for injured workers taking NSAIDs who are at risk for gastrointestinal events. There is no indication the injured worker was at risk for gastrointestinal event or had current gastrointestinal complaints to support the use of omeprazole. In addition, the request fails to specify a frequency. Therefore, the request is not medically necessary.

Aspen back brace (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Low Back, Lumbar supports

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The request for a back brace is not medically necessary. The CA MTUS/ACOEM Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The injured worker's date of injury is in 2012

and, therefore, he is no longer in the acute phase of symptom relief. As such, the request is not medically necessary.