

Case Number:	CM14-0219171		
Date Assigned:	01/09/2015	Date of Injury:	08/31/2012
Decision Date:	03/13/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	12/31/2014

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: Minnesota, Florida
 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 63 year old male, who sustained an industrial injury on 8/31/12. He has reported pain in right shoulder, back and legs. The diagnoses have included cervical/thoracic/lumbar spine sprain/strain, right shoulder impingement, right upper extremities and lumbar spine radiculopathy. Treatment to date has included physical therapy, TENS unit and medications. Currently, the IW complains of constant loss of sleep, right shoulder pain radiating towards hand, right neck pain and constant palpitations on middle back. MRI of the right shoulder showed increased signal in the supraspinatus but an MR arthrogram did not show a full thickness rotator cuff tear. (MRI) magnetic resonance imaging performed on 10/21/14 revealed L1-2, L2-3, L3-4, L4-5 and L5-S1 disc protrusion with mild to moderate canal stenosis. Physical exam on 12/19/14 revealed right shoulder with positive impingement, cervical spine tender with muscle spasms at C2-7, lumbar spine tender with muscle spasms at L1-5 and right middle paraspinal mass 2" x 3" was tender. The exact diagnosis of the mass has not been documented. On 12/11/14 Utilization Review non-certified a right shoulder arthroscopic subacromial decompression with distal clavicle resection, noting conservative care had not been carried out prior to considering surgery. Post op physical therapy was non-certified noting the surgery was non-certified. Utilization review non-certified a retrospective LSO brace noting LSO brace is not supported for treatment of low back pain by any criteria. Utilization Review non-certified Naproxen sodium noting long term use is discouraged and pain relief was not noted. Pantoprazole was non-certified as it was prescribed to prevent GI upset associated with Naproxen. Cyclobenzaprine was non-certified as it is a sedating muscle relaxant being utilized

for long term treatment, documentation does not identify acute pain or an acute exacerbation of chronic pain. Urine toxicology screen was non-certified noting a urine drug screen was performed on 10/28/14. The MTUS, ACOEM Guidelines, (or ODG) was cited. On 12/30/14, the injured worker submitted an application for IMR for review of right shoulder arthroscopic subacromial decompression with distal clavicle resection and post-op therapy, retrospective LSO brace, Naproxen sodium 550 mg, Pantoprazole 20 mg, Cyclobenzaprine 7.5 mg and random toxicology screen.

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 with distal clavicle resection:
Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 211, 213.

Decision rationale: California MTUS guidelines recommend arthroscopic decompression for impingement syndrome. However, this is not indicated for patients with mild symptoms or those who do not have activity limitations. Conservative care including cortisone injections can be carried out for 3-6 months before considering surgery. A comprehensive nonsurgical rehabilitation program with 2-3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program is recommended to treat rotator cuff inflammation, impingement syndrome or small tears. The documentation does not indicate a recent trial/failure of such a program. Recent corticosteroid injections are not documented. As such, the request for arthroscopic decompression with distal clavicle resection is not supported by guidelines and the medical necessity of this request is not established.

Post op therapy 12 sessions to the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 211, 213.

Decision rationale: The requested surgery is not medically necessary. Therefore the post-operative physical therapy is not needed.

Retrospective LSO Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: California MTUS guidelines indicate lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. In the absence of instability, fracture, or surgery, a lumbosacral orthosis is not supported for the treatment of low back pain. As such, the medical necessity of the request for a lumbosacral orthosis is not substantiated.

Naproxen sodium 550mg BID #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67, 68, 69.

Decision rationale: California MTUS chronic pain guidelines indicate NSAIDs are recommended at the lowest dose for the shortest period of time in patients with moderate to severe pain. For chronic low back pain NSAIDs are recommended as an option for short-term symptomatic relief. There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis with neuropathic pain. The injured worker is currently on opioids for pain and documentation indicates that opioids are helping him more than naproxen. There is also concern about risk for gastrointestinal events. As such, the request for Naproxen 550 mg bid # 90 is not supported and the medical necessity is not established.

Pantoprazole 20mg TID #90: Upheld

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

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

Decision rationale: Pantoprazole is a proton pump inhibitor which was prescribed to reduce the risk of gastrointestinal events concurrently with the use of naproxen. As the medical necessity of naproxen is not established, pantoprazole is not necessary. As such, the request for pantoprazole 20 mg tid # 90 is not supported, and the medical necessity is not substantiated.

Cyclobenzaprine 7.5mg TID PRN #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Cyclobenzaprine Page(s): 64.

Decision rationale: Chronic pain guidelines recommend nonsedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine is recommended for a short course of therapy. It is not recommended for chronic use. The greatest affect appears to be in the first 4 days of treatment. As such, the request for long-term use of cyclobenzaprine 7.5 mg tid prn # 90 is not supported and the medical necessity is not substantiated.

Random toxicology screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG Pain Chapter, Urine drug testing (UDT)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, ongoing management Page(s): 78. Decision based on Non-MTUS Citation Section: Pain, Topic: Urine drug testing

Decision rationale: The documentation indicates that a urine drug screen was performed in October 2014. There is no indication of aberrant behaviors. ODG guidelines recommend patients at low risk of addiction/aberrant behavior should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As such, the request for a repeat urine drug test is not medically necessary.