

Case Number:	CM15-0120518		
Date Assigned:	07/07/2015	Date of Injury:	06/19/2014
Decision Date:	09/18/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/22/2015

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, Indiana, Oregon
 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 45-year-old female, who sustained an industrial injury on 06/19/2014. She has reported subsequent left shoulder and upper extremity pain and was diagnosed with impingement syndrome, left, left lateral and medial epicondylitis, left de Quervain's syndrome and left carpal tunnel syndrome. X-ray of the shoulder/arm dated 04/23/2015 showed good glenohumeral relationship with no evidence of heterotopic calcifications, Type II acromion. Treatment to date has included medication, application of heat and ice, physical therapy and bracing. In a progress note dated 05/14/2015, the injured worker complained of left shoulder, arm, wrist and elbow pain. Objective findings were notable for tenderness to the left anterior shoulder region and periscapular area, painful range of motion, positive Neer impingement sign, Hawkin's sign, cross-chest, AC joint compression, Obrien's, Speed's, Yergason's and dynamic compression shear tests. The physician noted that the injured worker had been unresponsive to conservative treatment and was a candidate for surgery. Utilization review approved a request for left shoulder arthroscopic acromioplasty with distal claviclectomy with labral repair vs biceps tenodesis, post-operative physical therapy, cold therapy unit, Tylenol and abduction braces. Work status was temporarily totally disabled and the injured worker remained off work. A request for authorization of Sprix, associated surgical services including continuous passive motion unit, 21 day rental/purchase, urine drug screen, ART unit and pain pump, Terocin pain patches quantity of 30 and psychological consult was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sprix: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ketorolac Page(s): 72.

Decision rationale: CAMTUS chronic pain treatment guidelines, ketorolac, page 72 states that ketorolac is not indicated for chronic pain. Page 67, NSAIDs for acute low back pain, states that NSAIDs are likely no better than acetaminophen or placebo for low back pain. In this case other NSAIDs are in use and additional intranasal ketorolac is not medically necessary.

Associated surgical service: CPM (continuous passive motion) unit, 21-day rental/purchase: Upheld

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

Decision rationale: CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis and to what extent it exists, the request exceeds guidelines, the determination is not medically necessary.

Terocin pain patches Qty 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines lidocaine Page(s): 56.

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 56 and 57, regarding Lidocaine, may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In this case, there is no evidence of a neuropathic pain. The request is not medically necessary.

Associated surgical service: Urine drug screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines urine toxicology Page(s): 94.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 94-95, use of urine toxicology is encouraged particularly when opioids are prescribed. It states, opioids, steps to avoid misuse/addiction. The following are steps to avoid misuse of opioids, and in particular, for those at high risk of abuse: a) Opioid therapy contracts. See Guidelines for Pain Treatment Agreement. b) Limitation of prescribing and filling of prescriptions to one pharmacy. c) Frequent random urine toxicology screens. In this case there is insufficient evidence of chronic opioid use or evidence of drug misuse to warrant urine toxicology. The request is not medically necessary.

Psychological consult: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

Decision rationale: CA MTUS/ACOEM guideline Chapter 15, Stress Related Conditions, page 398, states, "it is recognized that primary care physicians and other non-psychological specialists commonly deal with and try to treat psychiatric conditions. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than six to eight weeks." In this case, the clinical notes do not demonstrate evidence of severe depression or schizophrenia to warrant specialist referral. Therefore, the request is not medically necessary.

Associated surgical service: ART unit: Upheld

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of E-stim for the shoulder. Per the ODG, Shoulder, electrical stimulation, "Not recommended. For several physical therapy interventions and indications (eg, thermotherapy, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy." As the guidelines do not support e-stimulation for the shoulder, the request is not medically necessary.

Associated surgical service: Pain pump: Upheld

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder pain pumps. Per the Official Disability Guidelines, Online edition, Shoulder Chapter, regarding postoperative pain pumps, "Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. Before these studies, evidence supporting the use of ambulatory pain pumps existed primarily in the form of small case series and poorly designed, randomized, controlled studies with small populations." In addition there are concerns regarding chondrolysis in the peer reviewed literature with pain pumps in the shoulder post-operatively. As the guidelines and peer reviewed literature does not recommend pain pumps, the request is not medically necessary. 1.) Ciccone WJ 2nd, Busey TD, Weinstein DM, Walden DL, Elias JJ. Assessment of pain relief provided by interscalene regional block and infusion pump after arthroscopic shoulder surgery. *Arthroscopy*. 2008 Jan; 24 (1): 14-9. 2.) ODG Online edition, 2014.3.) Matsen FA 3rd, Papadonikolakis A. Published evidence demonstrating the causation of glenohumeral chondrolysis by postoperative infusion of local anesthetic via a pain pump. *J Bone Joint Surg Am*. 2013 Jun 19; 95 (12): 1126-34.