

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/27/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	6/28/2013
Date of Injury:	3/2/2012
IMR Application Received:	7/30/2013
MAXIMUS Case Number:	CM13-0005136

- 1) MAXIMUS Federal Services, Inc. has determined the request for arthroscopic surgery to the left shoulder **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for thirty Norco ten **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Capsaicin gel 60gm **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for unknown visits with TENS unit **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for unknown ultrasound and therapeutic exercises **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/30/2013 disputing the Utilization Review Denial dated 6/28/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/13/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for arthroscopic surgery to the left shoulder **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for thirty Norco **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Capsaicin gel 60gm **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for unknown visits with TENS unit **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for unknown ultrasound and therapeutic exercises **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

This claimant is a 46-year-old female with complaints of pain. On 06/15/2012, electrodiagnostic studies were performed demonstrating that she was taking Vicodin at that time. She stated she had a right shoulder surgery in 2003. Exam revealed sensation was intact, reflexes were normal, and motor strength was normal. EMG and nerve conduction study was performed at that time. This was considered a normal EMG of the cervical spine and upper extremities, but an abnormal NCV study of the upper extremities revealed bilateral mild carpal tunnel syndrome. On 09/14/2012, she underwent comprehensive initial orthopedic evaluation. An MRI of the left shoulder was reviewed at that time, revealing tendinosis of the subscapularis, supraspinatus, and infraspinatus, and a SLAP tear of the superior and posterior/superior labrum, acromioclavicular arthrosis, subchondral cyst of the posterior aspect of the proximal humerus, and superior migration of the proximal humerus. Upon examination left shoulder inspection was unremarkable. She did have tenderness to palpation of the rotator cuff expance and active range of motion was measured with flexion 160 degrees, extension 40 degrees, and abduction 150 degrees. There was crepitus on

joint motion and she had a positive Hawkins and Neer's impingement test. She had a positive Speed's and Yergason's test. Apprehension test was negative and rotator cuff muscle strength was graded at 5-/5. Assessment included labral tear, left shoulder, biceps, and rotator cuff tendonitis. On 05/28/2013, this claimant was seen in clinic. At that time she still complained of pain. The pain was not objectively identified on a VAS scale, but she was given a Toradol and Decadron injection for pain. She was prescribed Norco 10 mg 1 every 6 hours for severe pain, Motrin 800 mg twice a day for pain with food, and capsaicin gel 60 gm for pain to be applied twice a day. Physical therapy to the left side of the neck and left shoulder 2 times a week for 4 weeks consisting of infrared, TENS, ultrasound, and therapeutic exercises were recommended at that time. On 05/29/2013, a urinalysis was performed revealing that there were no benzodiazepines detected and no opioids detected in her system at that time. On 06/26/2013, she returned to clinic, still complaining of pain, particularly about the left shoulder. Objectively, palpation revealed tenderness about the AC joint and rotator cuff with crepitus noted. Range of motion was tested and she had flexion of 110 degrees, extension of 30 degrees, and abduction at 100 degrees. Hawkins and Neer's test were positive. Drop arm test was positive. Plan at that time was to prescribe lidocaine patches, Motrin 800 mg twice a day, capsaicin gel 60 gm for pain to be applied twice a day, as well as physical therapy to the knee consisting of infrared, EMS, phonophoresis, and therapeutic exercises. On 07/01/2013, this claimant was taken to surgery for a preoperative diagnosis of left shoulder internal derangement and procedure performed at that time was left shoulder arthroscopy with subacromial decompression and extensive bursectomy and left shoulder arthroscopic labral debridement performed by [REDACTED] MD. He returned to clinic on 07/10/2013. At that time vital signs were stable and she was 10 days postoperative to the left shoulder with complaints of residual pain to the joint and electric-like sensation to the left upper extremity. Physical examination was not documented at that time. Plan was to provide conservative care, as well as medications. Medications include Vicodin 500 mg every 4 to 6 hours for severe pain, capsaicin gel 60 gm for pain to be applied twice a day. It was noted she would start physical therapy to the left shoulder 2 times a week for 4 weeks consisting of slow, progressive range of motion exercises for 15 minutes, application of hot packs over the area before the exercises and cold packs after the exercises and chiropractic care with myofascial release to the left shoulder once a week for 4 weeks.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

1) Regarding the request for arthroscopic surgery to the left shoulder:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 9 (Shoulder Complaints) (2004), pg. 210, which is part of MTUS, as well as the Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Indications for Surgery – Rotator Cuff Repair, and Surgery for SLAP Lesions, which are not part of MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pg 210-211, which is part of MTUS. In addition, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Shoulder Chapter, Surgery for SLAP Lesions, which is not part of MTUS.

Rationale for the Decision:

This request was previously reviewed on 07/01/2013. It was noted at that time that California MTUS/ACOEM do not reveal guidelines appropriate to the request for SLAP repair. Therefore, alternate guidelines were consulted consisting of Official Disability Guidelines. It was noted that guidelines stated that surgery for SLAP lesions may be recommended for type II lesions and for type IV lesions if more than 50% of the tendon was involved. It was noted that left shoulder arthroscopic surgery did not appear to be medically warranted, as the records revealed that a previous request for left shoulder arthroscopy with debridement and repair of the biceps and rotator cuff tendons, was certified previously. There was no indication that that certification was utilized by the requesting provider. In addition, the records indicate that further requests for left shoulder surgery were recommended non-certified. Therefore, the request was non-certified at that time. The subsequent medical records provided for this review indicate that an MRI had previously been performed 05/19/2012, which apparently showed tendinosis of the subscapularis, supraspinatus, and infraspinatus, a SLAP tear of the superior and posterior superior labrum, acromioclavicular arthrosis, subchondral cyst of the posterior aspect of the proximal humerus, and superior migration of the proximal humerus. For this review, California MTUS/ACOEM Shoulder Chapter was consulted, indicating that surgery considerations may be given if there are red flag conditions, such as an acute rotator cuff tear in a young worker, glenohumeral joint dislocation, activity limitation for more than 4 months should be demonstrated absent red flags, plus existence of a surgical lesion, and there should be failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion. There should be clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term for surgical repair. Prior to the employee undergoing surgery on 07/01/2013 to the left shoulder, it was noted that the employee did have a positive drop arm test, positive Hawkins test, and a positive Neer's test with slightly decreased range of motion to the left shoulder. However, no physical therapy notes were submitted for this review to objectively document that the employee had failure to increase range of motion or strengthen the musculature around the shoulder as recommended by California MTUS/ACOEM. It is important to note that the previous determination

stated that the request was non-certified because there was a SLAP lesion and a request had been made for a SLAP repair. Official Disability Guidelines are not consulted as California MTUS/ACOEM Shoulder Chapter does not specifically address a SLAP lesion. Official Disability Guidelines Shoulder Chapter indicates that surgery for a SLAP lesion may be recommended for “type II lesions, and for type IV lesions if more than 50% of the tendon is involved.” The records do not indicate that the employee had a type II or type IV lesion with 50% or more of the tendon involved. **The request for arthroscopic surgery to the left shoulder is not medically necessary or appropriate.**

2) Regarding the request for thirty Norco:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Hydrocodone section, which is part of MTUS.

The Expert Reviewer based his/her decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3) pgs 47-48 as well as Chronic Pain Medical Treatment Guidelines, Opioid, pgs 78 & 91, which are part of the MTUS.

Rationale for the Decision:

This request was previously assessed on 07/01/2013. At that time it was noted that the continued use of Norco was not medically indicated, as a review of the records indicated the employee had tried NSAIDs without relief, so Norco was prescribed. However, a review of the available records at that time indicated the employee had been utilizing Norco since 04/2012 and the records do not reveal significant subjective or objective or functional improvement associated with the long-term use of Norco. Based on a lack of support for long-term use of opiates and the absence of sustained functional improvement, the continued use of that medication was not warranted, and therefore, the request was non-certified. Drug screen performed on 09/19/2012 revealed the presence of hydrocodone and hydromorphone. The overall efficacy of this medication has not been demonstrated by the records provided. A drug screen performed on 05/29/2013 failed to reveal the presence of this medication. The records indicate that the employee had surgery on 07/01/2013. On 07/10/2013, the employee was seen in follow-up and was 10 days postoperative. Records do not indicate a pain score at that time to demonstrate the medical necessity of this medication. However, the patient was placed on Vicodin 500 mg every 4 to 6 hours for severe pain at that time. Lack of documentation of a pain scale to indicate objectively that the employee had pain, this request would not be supported by guidelines. California MTUS/ACOEM indicate that opiates appear to be “no more effective than safer analgesics for managing most musculoskeletal symptoms; they should be used only if needed for severe pain, and only for a short time.” California MTUS, Chronic Pain Medical Treatment Guidelines go further, indicating that 4 domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychological/psychosocial functioning, and the appearance of any potentially aberrant (or non-adherent) drug-related behaviors. As the pain score

has not been objectively identified, there is lack of documentation of significant pain for this employee to warrant this medication. **The request for thirty Norco is not medically necessary or appropriate.**

3) Regarding the request for Capsaicin gel 60gm:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Topical Analgesics, pgs 111-113, which is part of MTUS.

Rationale for the Decision:

This request was previously reviewed on 07/01/2013. Request was non-certified. At that time additional information was requested to support this request, and the request was non-certified. The additional medical records provided for this review fail to demonstrate the efficacy of this medication, as a pain scale was not provided in the most recent records. California MTUS/ACOEM does not specifically address this issue, but California MTUS, Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are “largely experimental in use with few randomized controlled trials to determine efficacy or safety.” Specifically for capsaicin, California MTUS, Chronic Pain Medical Treatment Guidelines indicate this medication is “recommended only as an option in patients who have not responded or are intolerant to other treatments.” Since a pain scale has not been documented and as there is lack of documentation of failure of other medications prior to this, this request is not supported by California MTUS, Chronic Pain Medical Treatment Guidelines. **The request for Capsaicin gel 60gm is not medically necessary and appropriate.**

4) Regarding the request for unknown visits with TENS unit:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), TENS, (transcutaneous electrical nerve stimulation), which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Criteria for the use of TENS, pg 116, which is part of MTUS.

Rationale for the Decision:

This request is for unknown visits with TENS unit. It is not stated what kind of visits these are, whether PT, OT, physician office visits, or chiropractic visits. California MTUS, Chronic Pain Medical Treatment Guidelines indicate criteria for use of TENS would include chronic intractable pain, documentation of pain of at

least 3 months duration, evidence that other appropriate pain modalities have been tried, including medication and failed. A 1 month trial of the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function, rental would be preferred over purchase during that trial. Other ongoing pain treatments should also be documented during the trial period, including medication usage. The records do not include documentation of the employee's pain scale and did not indicate documentation of a trial unit. They do not document if the employee had had a trial outcome in terms of pain relief or function or if it was used as an adjunct to ongoing treatment modalities within a functional restoration approach as recommended by guidelines. The records do not indicate evidence that other appropriate pain modalities have been tried, including medication and failed. As stated previously, a pain scale has not been documented by the most recent records. This request was previously non-certified, as there is lack of objective findings for the employee's reduction in pain medication or any other significant functional improvements. As such, this request is non-certified due to lack of support from California MTUS, Chronic Pain Medical Treatment Guidelines, the medical records, and the previous determination. **The request for unknown visits with TENS unit is not medically necessary and appropriate.**

5) Regarding the request for unknown ultrasound and therapeutic exercises:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), Ultrasound, which is part of MTUS.

The Expert Reviewer based his/her decisions on the Chronic Pain Medical Treatment Guidelines, Section Physical Medicine, pgs 98-99 and 124 as well as Postsurgical Treatment Guidelines, which are part of MTUS.

Rationale for the Decision:

This request is for unknown ultrasound and therapeutic exercises. The records do indicate that the employee now is status post left shoulder arthroscopic decompression with labral debridement performed on 07/01/2013. The records do not indicate the number of ultrasound or therapeutic exercises requested. Lacking documentation of the number of visits and lacking support from California MTUS, Chronic Pain Medical Treatment Guidelines, this request is not considered medically necessary. Additionally, without documentation of specific number, this request would not be supported by California MTUS Clean Copy for postoperative therapy regimen. **The request for unknown ultrasound and therapeutic exercises is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/skf

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

CM13-0005136