

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/25/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/5/2013
Date of Injury:	2/2/2011
IMR Application Received:	8/7/2013
MAXIMUS Case Number:	CM13-0008470

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Norco 10/325mg #60 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **x-force stimulator for bilateral shoulders is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/7/2013 disputing the Utilization Review Denial dated 8/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/10/2013. 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 **Norco 10/325mg #60 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **x-force stimulator for bilateral shoulders 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 Physical Medicine and Rehabilitation, and is licensed to practice in Oklahoma. 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:

The patient is a 60 year old male who reported an injury on 02/02/2011. An operative note was submitted on 08/17/2012 by Dr. [REDACTED], which indicated that the patient underwent right shoulder arthroscopy with extensive debridement of the superior labral tear, and an arthroscopic acromioplasty with ligament release. The patient was then seen by Dr. [REDACTED] on 01/10/2013 for a follow-up visit of the right shoulder. Physical examination revealed no swelling, no atrophy, no deformities, mild pain with palpation over the anterior aspect, normal range of motion, positive impingement signs, no neurological or sensory deficits, and 4/5 strength. The treatment plan included continuation of stretching and strengthening exercises with a re-evaluation in 6 weeks. The patient was then seen on 02/08/2013. The patient complained of 5/10 pain. Objective findings included minimal pain to palpation over the anterior shoulder and lateral shoulder, slightly restricted range of motion, slight pain with movement of the joint, normal sensation and motor strength, and normal temperature, texture, and color of the upper extremity. The treatment plan included continuation of current treatment and return to work with modified duties. A medical evaluation was then conducted by Dr. [REDACTED] on 03/05/2013. Current complaints included 2/10 to 6/10 pain with weakness and limited range of motion of the right shoulder. Current medications included hydrocodone on an as needed basis. Physical examination of the right shoulder revealed no deformity, no subluxation, no localized tenderness, slight tenderness along the anterior acromion process, minimal atrophy of the deltoid noted, tenderness over the bicipital groove, slightly decreased range of motion, and 20% loss of strength.

Diagnoses included a sprain and contusion of the right shoulder, rupture of the long head of biceps of the right shoulder, status post arthroscopic decompression and debridement of the right shoulder, and tendinopathy of the right shoulder. It was determined at that time that the patient had reached maximum medical improvement as of that date on 03/05/2013. The patient was then given a 9% whole person impairment rating. Future treatment would include occasional visits to the treating physician 3 to 4 times per year, occasional use of steroid injections, regular exercise program, and anti-inflammatory medication on an as needed basis. The patient was again seen by Dr. [REDACTED] on 04/04/2013. The patient complained of continued pain in the right shoulder with difficulty lifting or using the arm. Physical examination revealed mild tenderness, 5/5 strength, limited range of motion, and no motor or sensory deficits. The treatment plan included corticosteroid injections. The patient was again seen by Dr. [REDACTED] on 05/16/2013 for similar complaints of right shoulder pain. Physical examination revealed no significant changes, and the treatment plan included a return visit on an as needed basis only. The patient was then seen by Dr. [REDACTED] on 06/28/2013 and 07/26/2013 with complaints of right shoulder aching pain and soreness. Objective findings were not provided. The treatment plan included authorization for an MRI and MRA of the left and right shoulder, prescriptions for a cortisone injection of the right AC joints, request for authorization for an X Force Stimulator, and a request for authorization for Norco 10/325 mg #60. An unofficial arthrogram report of the right shoulder was submitted by Dr. [REDACTED] on 07/12/2013, which indicated degenerative AC joint with bony hypertrophy, fraying along the insertion of the supraspinatus tendon without tear defect, and deficiency of the intra-articular portion of the long head of biceps tendon consistent with given history of previous tear. A primary treating physician's orthopedic report was submitted by Dr. [REDACTED] on 07/29/2013. Present complaints included 8/10 right shoulder pain with popping and clicking. The patient also reported burning, numbness, and tingling to the right and fingers with painful range of motion. Physical examination of the shoulders revealed tenderness to palpation of the acromioclavicular joint, coracoid process, and long head of the biceps, negative orthopedic testing, decreased range of motion on the right, 4/5 strength, and normal neurological evaluation. Recommendations included physical therapy, acupuncture, TENS unit, an MRI and MR arthrogram of the right and left shoulder, a urine toxicology screening, and medication management. A utilization review report was then submitted on 08/05/2013, for the request of Norco 10/325 mg and a rental of an X Force Stimulator. The requests were denied at that time. Copy and Paste from DRF]]

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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Norco 10/325mg #60:

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, Opioids, pp. 74-82, which is a part of MTUS, and Other Evidence Based Guidelines which is not a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, pp. 74-82, which is a part of MTUS.

Rationale for the Decision:

California MTUS Guidelines state that short-acting opioids are used for controlling chronic pain, and often used for intermittent and breakthrough pain. The use of opioids should be a part of a treatment plan that is tailored to the patient. A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Additionally one (1) physical and psychosocial assessment by the treating doctor to assess whether a trial of opioids should occur. For the ongoing management with opioid therapy, review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. Opioids should be discontinued when there is no overall improvement in function, unless there are extenuating circumstances. In this case the medical records submitted for review do not indicate that the employee has failed a trial of non-opioid medication, neither does the records evidence a psychosocial assessment prior to the request for an opioid. Additionally, there is no documented evidence of satisfactory response to treatment by decreased pain, increased level of function, or improved quality of life. **The request for Norco 10/325mg #60 is not medically necessary and appropriate.**

2) Regarding the request for x-force stimulator for bilateral shoulders:

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, Transcutaneous Electrical Nerve Stimulation (TENS) therapy, pp. 114-117, which is a part of MTUS.

The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

MTUS Guidelines state that TENS therapy is not recommended as a primary treatment modality, but a one (1) month home-based TENS trial may be considered as a non-invasive conservative option. Documentation of pain for at least a 3 month duration should occur. There should be evidence that other appropriate pain modalities have been tried and failed. A treatment plan including the specific short and long-term goals of treatment with the TENS unit should be submitted. The clinical notes submitted for review, do not indicate that this employee has failed a trial of other appropriate pain modalities prior to the request for a TENS unit. There is also no documentation of a treatment plan that includes specific short and long-term goals of treatment with the TENS unit.

Additionally noted, the employee's work-related injury involved the right shoulder, and there is no documentation submitted that provides evidence of a significant abnormality of the left shoulder to warrant the need for treatment of bilateral shoulders at this time. **The request for X-Force Stimulator for bilateral shoulders 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

/sce

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.