

Case Number:	CM14-0144906		
Date Assigned:	09/12/2014	Date of Injury:	03/22/2013
Decision Date:	10/07/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/08/2014

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. The expert reviewer is Board Certified in Orthopaedic 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 54-year-old female detention services officer This 54-year-old female detention services officer sustained an industrial injury on 3/22/13 relative to a trip and fall. Injury was reported to the shoulder, neck, and upper back. Conservative treatment for the shoulder had included activity modification, physical therapy, corticosteroid injection, and anti-inflammatories. The 11/11/13 left shoulder ultrasound findings documented supraspinatus tendinosis and biceps tendinosis. The 6/27/14 treating physician report cited grade 7-8/10 persistent left shoulder pain despite conservative treatment. MRI findings confirmed impingement syndrome. Left shoulder exam findings documented flexion 160, abduction 145, and external rotation 80 degrees with crepitus. There was severe supraspinatus, moderate greater tuberosity, mild biceps tendon, and severe acromioclavicular joint tenderness. Rotator cuff strength was 4/5. There were positive compression and impingement tests. The patient was reported an excellent candidate for arthroscopic left shoulder evaluation, subacromial decompression, and distal clavicle resection. The 8/20/14 utilization review certified the requested left shoulder surgery. The associated request for Norco 5/325 mg #120 was partially certified to #60 for short term post-operative use. The request for a Surgi-Stim unit rental and purchase was modified to a 30-day rental of a TENS unit consistent with transcutaneous electrotherapy guidelines. The request for a Coolcare cold therapy unit was modified to a 7-day rental consistent with guidelines. The request for Zanaflex was denied as there was no evidence of first line analgesic failure or evidence of musculoskeletal spasms. The requests for continuous passive motion unit and abduction pillow were denied as guideline indications had not been met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, and Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, and Criteria for use, Hydrocodone/Acetaminophen Page(s): 76-80, 91.

Decision rationale: The California MTUS recommend the use of Hydrocodone/Acetaminophen (Norco) for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Short-acting opioids, also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling both acute and chronic pain. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guideline criteria have been met for the post-operative use of Norco. The 8/20/14 utilization review partially certified the request for Norco 5/325 mg from #120 to #60 for short term post-operative use. There is no compelling reason to support the medical necessity of Norco beyond the amount already approved. Therefore, this request for is not medically necessary.

Zanaflex 4mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain) Page(s): 63-66.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines indicate that Zanaflex is a muscle relaxant that is FDA approved for the management of spasticity. Guidelines additionally cite studies demonstrating efficacy for low back pain and one study recommending use as a first line option for treatment of myofascial pain. In general, non-sedating muscle relaxants are recommended with caution as a second-line option for short term treatment of acute exacerbation in patients with chronic lower back pain. Guideline criteria have not been met. There is no current evidence of spasticity to support the medical necessity of this medication. The routine post-op use of this medication is not recommended by guidelines. There is no compelling reason to support the medical necessity of this medication in the absence of spasticity. Therefore, this request is not medically necessary.

Home passive motion (CMP) device for forty-five days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, and Continuous Passive Motion (CMP).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous Passive Motion (CPM).

Decision rationale: The California MTUS are silent regarding continuous passive motion (CPM) units. The Official Disability Guidelines recommend CPM units as an option for adhesive capsulitis. Routine post-operative use in shoulder surgery is not recommended. Guideline criteria have not been met. Clinical exam does not support the diagnosis of adhesive capsulitis. There is no compelling reason for CPM in the absence of guideline support. Therefore, this request is not medically necessary.

Surgi-stim unit; ninety days, then purchase: Upheld

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

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

Decision rationale: Under consideration is a request for post-operative Surgi-Stim rental and purchase. The Surgi-Stim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES for post-operative rehabilitation. Galvanic stimulation is considered investigational for all uses. Guidelines support the use of post-op interferential current if significant pain limits the ability to perform exercise or physical therapy treatment. Guideline criteria have not been met. There is no indication that post-operative pain management will be insufficient to allow this patient to perform exercise or physical therapy treatment. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Guidelines clearly do not support the use of galvanic stimulation. The 8/20/14 utilization review modified this request and certified a TENS unit for 30 days of post-operative use. There is no compelling reason to support additional electrotherapy in the absence of guideline support. Therefore, this request is not medically necessary.

Coolcare cold therapy 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 (ODG) Shoulder, Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous Flow Cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after

surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. This request for an unknown length of use is not consistent with guidelines. The 8/20/14 utilization review modified this request to allow for 7-day rental. There is no compelling reason to support the medical necessity of a cold therapy unit beyond guideline recommendation and the 7-day rental already certified. Therefore, this request is not medically necessary.

Abduction pillow, large: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Post-Operative Abduction Pillow Sling.

Decision rationale: The California MTUS is silent regarding post-op abduction pillows. The Official Disability Guidelines recommend abduction pillow slings as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. There is no documentation that this patient had a massive rotator cuff tear or that an open repair is anticipated. Therefore, this request is not medically necessary.