

Case Number:	CM14-0005514		
Date Assigned:	04/07/2014	Date of Injury:	12/03/2012
Decision Date:	07/17/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	01/13/2014

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 Orthopedic Surgeon and is licensed to practice in Texas. 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:

The injured worker is a 34-year-old male who reported injury on December 03, 2012; the mechanism of injury was a motor vehicle accident. The diagnoses include supraspinatus tendinosis with partial tear left shoulder, left shoulder labral tear, and sprain left shoulder. The injured worker's medication history included Soma and tramadol as of at least March 2013. The injured worker underwent a urine drug screen on April 18, 2013, June 13, 2013 and July 18, 2013, which were inconsistent for prescribed and non-prescribed medications. The injured worker underwent a urine drug screen on November 26, 2013 no results were provided. The injured worker was treated with physical therapy and an injection in 2012. The injured worker underwent an MRI of the left shoulder on January 08, 2013 with findings of supraspinatus tendinosis with superimposed low-grade intrasubstance partial tear involving the anterior fibers at the footprint. There was linear signal abnormality involving the anterior and anterior inferior aspects of the fibro cartilaginous labrum, concerning for a labral tear. There was apparent superior subluxation of the distal clavicle with respect to the distal acromion, with a normal acromioclavicular joint, which could be within normal limits or related to grade I acromioclavicular joint separation. The documentation of August 26, 2013 revealed the injured worker had complaints of painfulness and achiness in the left shoulder. The injured worker had positive tenderness to the bilateral acromioclavicular joints and coracoid processes. The injured worker had tenderness to palpation in the coracoacromial ligament on the left side. The injured worker had a positive Neer's sign. The injured worker had decreased range of motion in flexion, extension, abduction, adduction, and internal rotation. There was pain on internal rotation, external rotation, flexion, abduction, and adduction bilaterally. The injured worker additionally had decreased range of motion in the right shoulder in flexion, extension, abduction, adduction, internal rotation, and external rotation. The discussion included the injured worker had trialed

physical therapy and a cortisone injection with short-lived benefit. The injured worker had failed all conservative modalities. The treatment plan included a left shoulder subacromial decompression with labral repair. It was further indicated the injured worker underwent a urine drug screen, which revealed a positive result for fentanyl and morphine. The treatment plan additionally included a refill of Ultram 50 mg #60 one by mouth every 6 hours and Soma 350 mg 1 daily, as well as Celebrex 200 mg and a urine drug screen for evaluation of the medication intake the injured worker was currently taking. It was indicated the injured worker was scheduled to undergo an MRA in January 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

ULTRAM 50MG (#60): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California MTUS Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker was being monitored for aberrant drug behavior and side effects. The duration of use was since at least March 2013. There was a lack of documentation of objective functional improvement and an objective decrease in pain with the medication. Given the above, the request is not medically necessary.

SOMA 350MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma (Carisoprodal).

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

Decision rationale: The California MTUS Guidelines recommend muscle relaxants as a second line treatment for short-term acute low back pain. The recommended timeframe is less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication since at least March 2013. There was a lack of documentation of objective functional benefit. The physical examination failed to indicate the injured worker had muscle spasms. The request as submitted failed to indicate the frequency for the requested medication and the number of refills being requested. Additionally, there was a lack of documentation indicating a necessity for refills. Given the above, the request is not medically necessary.

URINE DRUG TESTING: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend urine drug screens for documented issues of abuse, addiction, or poor pain control. The clinical documentation submitted for review indicated the injured worker had multiple inconsistent urine drug screens. The injured worker was noted to have a urine drug screen on November 26, 2013 and there was no documentation of results or rationale to repeat a urine drug screen. Given the above, the request is not medically necessary.

A LEFT SHOULDER ARTHROSCOPY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 211, table 9-6. Decision based on Non-MTUS Citation ODG Indications for Surgery - Acromioplasty.

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

Decision rationale: The California MTUS/ACOEM Guidelines do not specifically address diagnostic arthroscopy. The request as submitted failed to indicate whether the request was for a diagnostic arthroscopy or an arthroscopy as part of the subacromial decompression. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain and functional limitations continue despite conservative care. The clinical documentation submitted for review indicated the imaging had positive findings and there was documentation of a failure of conservative care. However, as the imaging was conclusive, the request for a left shoulder arthroscopy is not medically necessary.

A SUBACROMIAL DECOMPRESSION WITH LABRAL REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 211, table 9-6. Decision based on Non-MTUS Citation ODG Indications for Surgery - Acromioplasty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 20-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Surgery for SLAP lesions.

Decision rationale: The ACOEM Guidelines indicate that surgical consultations are appropriate for injured workers who have red flag conditions, activity limitation for more than 4 months plus

the existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus the existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the long and short term from surgical repair. They further indicate the surgery for impingement syndrome is arthroscopic decompression. There should be documentation of activity limitations and conservative care, including cortisone injections, for at least 3 months to 6 months before surgery. Additionally, there should be documentation of a rotator cuff condition. The clinical documentation submitted for review indicated the injured worker underwent an MRI. The MRI revealed supraspinatus tendinosis with superimposed low-grade intrasubstance partial tear involving the anterior fibers. Additionally, there was an apparent superior subluxation of the distal clavicle with respect to the distal acromion, which was opined, could be a normal finding or it could be related to grade I acromioclavicular joint separation. The injured worker had a positive Neer's sign on the left. This portion of the request would be supported. The ACOEM guidelines do not address labral tears. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that surgery for SLAP lesions is recommended for a type II lesion or a type IV lesion if more than 50% of the tendon is involved. The clinical documentation submitted for review failed to support a Labral tear with objective MRI findings. It was indicated the injured worker was scheduled to undergo an MRA in January 2014. Those results were not available for review. Given the above, the request is not medically necessary.

SURGI STIM MULTI MODALITY STIMULATOR: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

PRO-TECH MULTI-STIM UNIT: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

PAIN PUMP: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

A CONTINUE PASSIVE MOTION UNIT: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

Q-TECH RECOVERY SYSTEM: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

SHOULDER SLING: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

PHYSICAL THERAPY (UNSPECIFIED): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.