

<b>Case Number:</b>	CM14-0012672		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	05/22/2012
<b>Decision Date:</b>	06/26/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/31/2014

### 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 Internal Medicine 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:

The patient is a 45 year old male who was injured on 05/22/2012 when using equipment which turned his left shoulder and right wrist from torque action very violently and intensely. Prior treatment history has included the patient undergoing left shoulder arthroscopy on 03/15/2013 with revision surgery on 11/26/2013. He has received injection into the right shoulder and two cortisone injections into the left shoulder. The patient's medications include the following: Tramadol ER, Norco, Ibuprofen, Topical creams, Fexmid, and Prilosec. Diagnostic studies reviewed include an MRI of the shoulder revealing tear of the supraspinatus tendon, near the insertion site and greater tuberosity with fluid in the subacromial subdeltoid bursa indicating a full thickness tear; and horizontal tear of the superior glenoid labrum. Progress note dated 12/16/2013 documented the patient with complaints of worsening posterior left shoulder pain and moderate right shoulder pain. Objective findings on examination reveal an incision on the left shoulder which appears to be clean, dry and intact. Range of motion flexion 130 degrees bilaterally, extension 40 degrees on right and 30 degrees on left, abduction 130 degrees bilaterally, adduction 40 degrees on right and 30 degrees on left, internal rotation 60 degrees on right and 45 degrees on left, external rotation 60 degrees on right and 40 degrees on left. Impingement test is noted positive on the left. Assessment includes Status post left rotator cuff repair with recurrent tear. Status post revision surgery of the left shoulder. Right shoulder internal derangement. Left rotator cuff syndrome. Left shoulder recurrent dislocation. Weight gain (30 pounds). Treatment Plan includes a recommendation by [REDACTED] for an initial internal consultation and a weight loss program; MRI of the right shoulder to be done to rule out internal derangement; and a refill of Flexeril 7.5 mg to reduce muscle spasm.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FLEXERIL 7.5MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CYCLOBENZAPRINE (FLEXERIL) Page(s): 41, 64. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 41 & 64

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Cyclobenzaprine (Flexeril®) Page(s): 64, 41-42.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines Cyclobenzaprine is recommended as an option, using a short course of therapy to decrease muscle spasm. Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. In this case, this patient has bilateral shoulder and right wrist pain. In this case, the patient has been prescribed this medication since July 2013 which exceeds the guidelines recommendation of 2-3 weeks. Additionally, the most recent progress reports did not document evidence of muscle spasm on physical exam. Therefore, the request for Flexeril 7.5mg # 90 is not medically necessary and appropriate.

**WEIGHT LOSS PROGRAM:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Independent Medical Examinations and Consultations, Chapter 7, page 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47. Decision based on Non-MTUS Citation Center for Disease Control and Prevention (CDC) (2011), "Losing Weight; What is healthy weight loss?" (online), [http://www.cdc.gov/healthyweight/losing\\_weight/index.html](http://www.cdc.gov/healthyweight/losing_weight/index.html)

**Decision rationale:** CA MTUS guidelines do not specifically address a weight loss program but indicates that active The California MTUS guidelines do not specifically address a weight loss program but indicates that active physical treatment, cognitive-behavioral treatment along with strength training, stretching and progressive walking can have long term benefits. The CDC indicates lifestyle change and reduced caloric intake are essential to successful weight loss. In this case, there is no documentation of patient's current weight and BMI as well as weight prior to the injury. There is no documentation of a walking program or a diet plan that were initiated. Therefore, the request for a weight loss program is not medically necessary and appropriate.

**RETROSPECTIVE MRI RIGHT SHOULDER (DOS 1/27/2014):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),  
Shoulder, MRI

**Decision rationale:** According to the California MTUS/ACOEM guidelines, MRI is recommended if there is "physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon) and failure to progress in a strengthening program intended to avoid surgery." The Official Disability Guidelines (ODG), "MRI is the most useful technique for evaluation of shoulder pain due to subacromial impingement and rotator cuff disease and can be used to diagnose bursal inflammatory change, structural causes of impingement and secondary tendinopathy, and partial- and full-thickness rotator cuff tears." In this case, this patient complains of bilateral shoulder and right wrist pain. The provider has requested MRI of the right shoulder to rule out internal derangement; however, there is no documentation of right shoulder physical exam findings that suggests any structural abnormalities. Also, there is no documentation that the patient has tried and failed a conservative care including physical therapy program or HEP. Thus, the retrospective request for MRI of the right shoulder is not medically necessary and appropriate.