

Case Number:	CM14-0121214		
Date Assigned:	08/06/2014	Date of Injury:	04/12/2012
Decision Date:	09/11/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	07/31/2014

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 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 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 59-year-old male sustained an industrial injury on 4/12/12. The mechanism of injury was not documented. Past medical history was positive for diabetes. The 4/16/13 right shoulder MRI documented post-surgical findings with 2 anchors in the greater tuberosity. There was a full-thickness rotator cuff tear involving the supraspinatus and infraspinatus tendon with 3.5 cm retraction. Subscapularis tendinosis was noted. There was evidence of an acromioplasty and postsurgical changes to the acromioclavicular (AC) joint. The 6/14/13 left shoulder MRI revealed a full-thickness rotator cuff tear involving the supraspinatus and infraspinatus with retraction and muscle atrophy. There was moderate subscapularis tendinosis and severe AC degenerative joint disease. The progress reports in 2014 have noted complaints of right shoulder pain but no clinical exam findings were documented. The 7/2/14 treating physician progress report documented physical exam findings of decreased left shoulder flexion and abduction with a positive impingement sign. Right shoulder pain was reported increased with restricted range of motion and numbness and tingling. The treatment plan noted the 6/6/14 AME (agreed medical evaluation) recommendations for left shoulder rotator cuff repair surgery. Medications were prescribed without indications or documentation of prior benefit. The most recent orthopedic surgeon report was 8/22/13. The 7/18/14 utilization review modified the request for left shoulder surgery to an orthopedic surgeon consultation for surgical evaluation and planning. The requests for oral and topical medications were denied as there were no documented indications or benefit consistent with guidelines. The right shoulder MRI was denied as there was no change in functional status to support repeat imaging.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI).

Decision rationale: The California MTUS ACOEM Guideline criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure. The Official Disability Guidelines state that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Guideline criteria have not been met. A right shoulder MRI was performed on 4/16/13 with postsurgical findings and a full-thickness rotator cuff tear. There is no indication in the records of significant clinical or functional change to warrant repeat imaging. Therefore, this request for right shoulder MRI is not medical necessity.

Omeprazole DR 20mg, #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The California MTUS guidelines recommend the use of proton pump inhibitors (PPIs), such as Prilosec, for patients at risk for gastrointestinal events. Risk factors include age greater than 65 years, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple non-steroidal anti-inflammatory drug (e.g., NSAID + low-dose ASA). PPIs are reported highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Guideline criteria for intermediate gastrointestinal risk factors have not been met. There is no documentation of a history of gastrointestinal issues or difficulty with NSAID use. Continued NSAID use is not recommended. Therefore, this request for Omeprazole DR 20mg #30 with 2 refills is not medically necessary.

Hydrocodone (Norco)-APAP 10/325mg, #120 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use. Opioids, specific drug list Page(s): 76-80,91.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines support 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Guideline criteria have not been met for continued use of this medication in the absence of guideline-required functional benefit. Records indicate that discontinuation has been recommended since 2/6/14 based on an absence of documented benefit. A one-month supply was certified for the purposes of weaning on 2/6/14. Given the absence of documented functional improvement, this request for Hydrocodone (Norco)-APAP 10/325mg, #120 with 2 refills is not medically necessary.

Capsaicin 0.025% cream with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: The California MTUS indicates that topical analgesics in general are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Capsaicin is supported as an option in patients who have not responded or are intolerant to other treatments. Guideline criteria have not been met. There is no current documentation that the patient has been intolerant or has not responded to appropriate pain modalities. Records suggest that the patient has been using this topical medication since early 2014 with no documentation of any specific benefit. Given the absence of guideline support, this request for Capsaicin 0.025% cream with 2 refills is not medically necessary.

Naproxen Sodium 550mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-72.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) guidelines state non-steroidal anti-inflammatory drugs (NSAID), such as Naproxen are indicated for short term lowest dosage treatment of symptoms associated with osteoarthritis. Guidelines indicate that there is no evidence of long-term effectiveness for pain or function. NSAIDs are recommended at the lowest dose for the shortest period of time for patients with moderate to severe pain from osteoarthritis. NSAIDs are recommended for short-term symptomatic relief in

patients with chronic back pain. Guideline criteria have not been met for continued use. There is no documentation of functional improvement with the use of this medication. The 2/6/14 utilization review recommended approval of one additional month of Naproxen to allow the provider an opportunity to define benefit. The patient has been using Naproxen since at least 1/15/14 with no documentation of functional improvement or pain reduction with use. Given the absence of guideline support for long term use and lack of documented benefit, this request for Naproxen Sodium 550mg, #60 with 2 refills is not medically necessary.

Left shoulder surgery: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-211.

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. Guidelines state that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. Guideline criteria have not been met. The current request has been presented by the treating physician, not the orthopedic surgeon. A specific surgical procedure is not identified. The 7/18/14 utilization review modified this request and approved an orthopedic surgical consult for re-evaluation and surgical management. There is evidence of a full thickness rotator cuff tear and severe acromioclavicular degenerative joint disease. There were limited clinical findings and no functional assessment documented. There are no compelling reasons to support the medical necessity of a non-specific surgery pending surgical consultation and recommendations. Therefore, this request for left shoulder surgery is not medically necessary.