

Case Number:	CM14-0086552		
Date Assigned:	07/23/2014	Date of Injury:	07/27/2010
Decision Date:	08/27/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	06/10/2014

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 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 51-year-old male who reported an injury on 07/27/2010 due to accumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to his left shoulder. The injured worker's treatment history included surgical repair, injections, physical therapy, and medications. The injured worker was evaluated on 04/14/2014. It was documented that the injured worker had occasional locking of the right knee. It was also noted that the injured worker had pain with overhead lifting of the left shoulder. Physical findings included restricted range of motion of the left shoulder documented as 60 degrees in flexion, 32 degrees in extension, 40 degrees in abduction, 28 degrees in adduction, 25 degrees in internal rotation, and 35 degrees in external rotation, with a positive impingement sign, Neer's test, Hawkins-Kennedy test, and empty can supraspinatus test on the left. The injured worker's diagnoses included status post lumbar spine surgery, cervical spine disc protrusion, left shoulder sprain/strain, left shoulder impingement, left shoulder rotator cuff syndrome, left frozen shoulder/adhesive capsulitis, status post right knee meniscectomy, right knee osteoarthritis, bilateral knee internal derangement, right knee chondromalacia patella, right knee medial meniscal tear, anxiety, and depression. The injured worker's treatment plan included shoulder arthroscopy with acromioplasty and rotator cuff repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroplasty with acromioplasty and rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212.

Decision rationale: The requested left shoulder arthroplasty with acromioplasty and rotator cuff repair is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend surgical intervention for shoulder injuries for patients who have significant clinical examination findings consistent with pathology identified on an imaging study that have failed to respond to conservative treatment. The clinical documentation submitted for review does support that the injured worker has failed conservative treatment and continues to have significantly limited and painful range of motion that would benefit from surgical intervention. However, the clinical documentation did not provide an imaging study to support the need for surgery at this time. As such, the requested Left shoulder arthroplasty with acromioplasty and rotator cuff repair is not medically necessary or appropriate.

Cyclobenzaprine 7.5mg #90: Upheld

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

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

Decision rationale: The requested Cyclobenzaprine 7.5mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation does indicate that the injured worker has been on this medication for an extended duration. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Cyclobenzaprine 7.5mg #90 is not medically necessary or appropriate.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 63.

Decision rationale: The requested Tramadol ER 150mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review fails to provide any

evidence that the injured worker is monitored for aberrant behavior or receives any type of pain relief or functional benefit resulting from medication usage. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Tramadol ER 150mg #30 is not medically necessary or appropriate.

Omeprazole 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 67.

Decision rationale: The requested Omeprazole 20mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing use of gastrointestinal protectants be supported by documented risk factors that support the injured worker is at risk for developing gastrointestinal related disturbances due to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support the need for ongoing use of this medication. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Omeprazole 20mg #60 is not medically necessary or appropriate.