

Case Number:	CM14-0089331		
Date Assigned:	07/23/2014	Date of Injury:	05/31/2006
Decision Date:	09/30/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/13/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 67 year-old male who was reportedly injured on 5/31/2006. The mechanism of injury is not listed; however, he worked as an electrician. The claimant underwent shoulder surgery on 7/31/2008. The most recent progress notes dated 3/19/2014 and 5/28/2014, indicate that there are ongoing complaints of shoulder pain. Physical examination demonstrated: actively and passively elevates to 45, external rotates to 30, internal rotates to his lumbosacral junction, adducts to 45, about 30 degrees of extension loss and his elbow full flexion; hand warm. No recent diagnostic imaging studies available for review. Diagnosis: Right shoulder adhesive capsulitis. Previous treatment includes Heelbo, sling and medications to include: Ibuprofen and tramadol. A request was made for chiropractic treatment 2 times a week for 6 weeks and tramadol ER 150 mg #90 with two refills, which were not certified in the utilization review on 6/6/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG -TWC - ODG Treatment Integrated Treatment/Disability Duration Guidelines; Shoulder (Acute & Chronic) - (updated 08/27/14).

Decision rationale: Official Disability Guidelines supports 9 visits of chiropractic treatment shoulder strains and sprains, in conjunction with a physical rehabilitation program. Review of the medical records reveals adhesive capsulitis after a work related injury in 2006; however, fails to document an ongoing rehabilitation program or physical therapy. As such, this request is not considered medically necessary.

Tramadol ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113.

Decision rationale: California Medical Treatment Utilization Schedule treatment guidelines support the use of tramadol (Ultram) for short-term treatment of moderate to severe pain after there is been evidence of failure of a first-line option and documentation of improvement in pain and function with the medication. Review of the medical records documents the use of other opioids; however, no documentation regarding anti-inflammatories and/or physical therapy over the previous two years. The guidelines do not support; therefore, it is not considered medically necessary.