

<b>Case Number:</b>	CM14-0109602		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	04/20/2014
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	06/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2014

### 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 is a 63 year old female with a 4/29/09 injury date. A 5/13/12 right shoulder MRI revealed a re-tear at the supraspinatus tendon with medial retraction of 2.2 cm and no evidence of SLAP tear. In a 6/2/14 note, the patient complained of neck, left wrist, and left shoulder pain. Objective findings included tenderness in the shoulders with decreased motion, spasms, and positive empty can and apprehension tests. The provider recommended open right rotator cuff repair and SLAP repair. In a 5/5/14 note, the patient complained of neck, left wrist, and left shoulder pain. Objective findings included tenderness in the shoulders with decreased motion, spasms, and positive empty can and apprehension tests. The provider again was planning on right shoulder surgery. Diagnostic impression: right shoulder rotator cuff tear. Treatment to date: right shoulder rotator cuff repair (failed), home exercise, physical therapy, medications. A UR decision on 6/23/14 denied the requests for right shoulder rotator cuff repair and right shoulder SLAP (superior labral tear from anterior to posterior) repair because there was insufficient documentation of previous conservative treatment. The requests for pre-op medical clearance, post-op physical therapy, Flexeril 7.5 mg, Prilosec 20 mg, and Tramadol ER 150mg were denied because the associated surgical procedures were not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder rotator cuff repair QTY:1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter-Rotator cuff repair

**Decision rationale:** The CA MTUS states that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation; conservative treatment of full thickness rotator cuff tears has results similar to surgical treatment, but without the surgical risks, and further indicate that surgical outcomes are not as favorable in older patients with degenerative changes about the rotator cuff. In addition, the ODG criteria for repair of full-thickness rotator cuff tears include a full-thickness tear evidenced on MRI report. However, there was insufficient documentation to support the request. Although the patient had a previous rotator cuff repair and a 2012 MRI showing a re-tear, it is unclear what conservative treatment, if any, has been done in the past 2 years. In addition, the physical exam was very brief and non-specific. There was no evidence of range of motion or weakness in specific muscle groups. Although the patient may be a candidate for repeat right shoulder rotator cuff repair, there is insufficient documentation to support the request at this time. Therefore, the request for right shoulder rotator cuff repair is not medically necessary.

**Right shoulder SLAP (superior labral tear from anterior to posterior) repair. QTY:1:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter-SLAP repair

**Decision rationale:** The CA MTUS and the ODG state that surgery for SLAP lesions is recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved, in addition to a history and physical findings consistent with a SLAP lesion; recent literature suggest poor outcome with a Worker's Compensation patient population and age over 40. However, there was no evidence of a labral tear in the 2012 MRI. In addition, a SLAP repair would not be recommended in a 63 year old patient because the results are disappointing. Therefore, the request for right shoulder SLAP (superior labral tear from anterior to posterior) repair is not medically necessary.

**Associated surgical service: Pre-op medical clearance:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery

**Decision rationale:** The CA MTUS does not address this issue. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for non-cardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. However, the associated surgical procedures were not certified. Therefore, the request for pre-op medical clearance is not medically necessary.

**Associated surgical service: Post-op Physical Therapy QTY: 18.00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The CA MTUS supports 40 physical therapy sessions over 16 weeks after rotator cuff repair surgery. However, the associated surgical procedures were not medically necessary. Therefore, the request for post-op physical therapy (18) is not medically necessary.

**Associated surgical service: Flexeril 7.5 mg. QTY: 90.00: 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): 41-42.

**Decision rationale:** According to page 41 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. However, only short courses of treatment are recommended and the current request is for 90 pills. In addition, the post-op use does not apply because the surgical procedure was not certified. Therefore, the request for Flexeril 7.5 mg #90 is not medically necessary.

**Associated surgical service: Prilosec 20 mg QTY: 60.00: 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 Page(s): 68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Prilosec)

**Decision rationale:** The CA MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as; gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. Prilosec is a proton pump inhibitor, PPI, used in treating reflux esophagitis and peptic ulcer disease. There is no comment that relates the need for the proton pump inhibitor for treating gastric symptoms associated with the medications used in treating this industrial injury. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. However, there remains no report of gastrointestinal complaints or chronic NSAID use. Therefore, the request for Prilosec 20 mg #60 is not medically necessary.

**Associated surgical service: Tramadol ER 150mg QTY: 30.00: 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 Tramadol, Opiates Page(s): 113, 78-81.

**Decision rationale:** The CA MTUS states that Tramadol (Ultram) is not recommended as a first-line oral analgesic. This medication has action on opiate receptors, thus criterion for opiate use per MTUS must be followed. The CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, given the 2009 date of injury, the duration of opiate use to date is not clear. There is no discussion regarding non-opiate means of pain control, or endpoints of treatment. The records do not clearly reflect continued analgesia, continued functional benefit, a lack of adverse side effects, or aberrant behavior. Although opiates may be appropriate, additional information would be necessary, as the CA MTUS Chronic Pain Medical Treatment Guidelines require clear and concise documentation for ongoing management. Non-certification here does not imply abrupt cessation for a patient who may be at risk for withdrawal symptoms. Should the missing criteria necessary to support the medical necessity of this request remain unavailable, discontinuance should include a tapering prior to discontinuing avoiding withdrawal symptoms. Therefore, the request for Tramadol ER 150 mg #30 is not medically necessary.