

Case Number:	CM14-0025444		
Date Assigned:	06/11/2014	Date of Injury:	02/03/2012
Decision Date:	01/27/2015	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	02/27/2014

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, has a subspecialty in ENTER SUBSPECIALTY and is licensed to practice in Minnesota. 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 50-year-old female with date of injury of 2/1/2010. She complains of neck pain and right shoulder pain. Per MRI scan of 10/21/13 there is abnormal signal intensity seen within the anterior and superior glenoid labrum that demonstrates slight gadolinium enhancement consistent with at least partial tear. The posterior and inferior labra are normal. The acromion is type I-II with mild proliferative changes seen in the acromioclavicular joint with impingement of the supraspinatus muscle/tendon junction with tendinosis changes seen. No tear, medial retraction or atrophy is present. There is mild to moderate amount of fluid seen in the glenohumeral joint, tracking into the subcoracoid and subdeltoid bursae, consistent with bursitis. There is mild amount of fluid seen in the biceps tendon sheath consistent with tenosynovitis. No evidence for tear or SLAP type of injury detected. The rest of the rotator cuff muscles and tendons are normal. Per examination of January 13, 2014 there was tenderness to palpation over the right rotator cuff muscles. Flexion of the right shoulder was 120 and abduction 120. Internal and external rotation were not tested. The impression was cervical spine disc protrusion with bilateral upper extremity radiculitis, cervical disc syndrome, and right shoulder mid-anterior and inferior labrum degenerative tear with impingement. Documentation indicates a physical therapy program in 2012 and 1 injection into the right shoulder. No recent comprehensive conservative treatment program of injections/exercises was documented. A request for arthroscopic decompression and labral repair of the right shoulder was noncertified by utilization review due to absence of a documented 3-6 months program of conservative care including cortisone injections and physical therapy or a supervised home exercise program. Clinical impingement signs were not demonstrated on physical exam. There was a clear lack of exhaustion of conservative care. The date and location of the shoulder injection was not given.

With regard to the request for manipulation under anesthesia, the treatment for adhesive capsulitis is aggressive PT and serial injections. Injection of corticosteroid combined with a simple home exercise program is effective in improving shoulder pain and disability in patients. Therefore the request for manipulation under anesthesia was noncertified. Similarly other requests including preop medical clearance, postoperative physical therapy were also noncertified. With regard to a request for Flexeril 7.5 mg for cervical muscle spasms approval was recommended for 30 days. A request for tramadol ER 150 mg was noncertified for lack of documentation of other analgesics being tried or other end-stage use. The request for Prilosec 20 mg was noncertified for lack of documentation of gastrointestinal issues. The independent medical review is requested for the noncertified issues.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder labral repair with manipulation under anesthesia, right shoulder acromioplasty: 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, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, Topic: Surgery for SLAP Lesions, Manipulation Under Anesthesia.

Decision rationale: California MTUS guidelines indicate surgical considerations if there is activity limitation for more than 4 months plus existence of a surgical lesion or failure to increase range of motion and strength of the musculature around the shoulder even with exercise programs plus existence of a surgical lesion or clear clinical and imaging evidence of a lesion that has been shown to benefit, and both the short and long-term from surgical repair. There is no evidence of a rotator cuff tear; however, there is evidence of impingement for which the guidelines recommend conservative care including cortisone injections combined with an exercise program for at least 3-6 months before considering surgery. 2 or 3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome or small tears is recommended. For adhesive capsulitis injections combined with a physical therapy program to improve the range of motion is recommended per ODG guidelines. For type I and 3 SLAP lesions no repair as indicated. The documentation does not indicate the presence of type II or type IV SLAP lesion. Based upon the above, the requests for arthroscopy of the right shoulder with acromioplasty, labral repair, and manipulation under anesthesia is not supported and as such the medical necessity is not established.

Preoperative medical clearance: 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, 213.

Decision rationale: The requested surgical procedure is not medically necessary. Therefore the request for preoperative medical clearance is also not medically necessary.

Postoperative physical therapy 2 times per week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-211, 213.

Decision rationale: The requested surgical procedure is not medically necessary. Therefore the requested postoperative physical therapy is also not medically necessary.

Psychiatric consult: Overturned

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
Psychological Evaluations Page(s): 100-101.

Decision rationale: Chronic pain medical treatment guidelines recommend psychological evaluations not only with selected use in pain problems but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury or work related. The interpretation of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. Psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. The request for a consultation is therefore appropriate and medically necessary.

Preoperative physical therapy 2 times per week for 4 weeks: Overturned

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 Physical Medicine Page(s): 98-99.

Decision rationale: Chronic pain guidelines recommend active therapy, based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy may require supervision from a therapist or medical provider. Patients are instructed and expected to continue with active therapies at home as an extension of the treatment process in order to

maintain improvement levels. Physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to one or less plus active self-directed home physical medicine. The documentation indicates diagnoses pertaining to the shoulder as well as cervical spine with radiculitis in both upper extremities. Therefore 8-10 visits over 4 weeks are recommended per guidelines. This can be combined with subacromial corticosteroid injections of the shoulder as part of a comprehensive conservative treatment for impingement syndrome as well as adhesive capsulitis based upon the above guidelines.

Prescription of Flexeril (Cyclobenzaprine) 7.5mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain) Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: Chronic pain guidelines recommend Cyclobenzaprine for a short course of therapy only. It is not recommended for chronic use. It is a skeletal muscle relaxant and is a central nervous system depressant. The greatest effect appears to be in the first 4 days of treatment. Muscle relaxants are a second line option for short-term treatment of acute exacerbations of chronic pain such as low back pain. Based upon guidelines chronic use Cyclobenzaprine is not recommended. As such, the modified approval of the request for Flexeril 7.5 mg to 30 day supply by UR was appropriate. The request as stated for Flexeril 7.5 mg with no frequency of dosage or duration specified is not supported by guidelines and as such was not medically necessary.

Prescription of Tramadol ER 150 mg capsules, #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol Page(s): 93,94,113.

Decision rationale: Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first line oral analgesic. As an opioid it is subject to the same steps to avoid misuse/addiction. The documentation does not indicate use of other first-line analgesics and as such, the request for Tramadol is not supported by guidelines and was not medically necessary.

Prescription of Prilosec (Omeprazole) 20 mg: 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 and Cardiovascular Risk Page(s): 68.

Decision rationale: Omeprazole is a proton pump inhibitor used in patients on NSAIDs at intermediate risk for gastrointestinal events and no cardiovascular disease. Long-term PPI use has been shown to increase the risk of hip fracture. The documentation does not indicate risk factors such as age over 65, history of peptic ulcer disease, GI bleeding or perforation, concurrent use of aspirin, corticosteroids, or and anticoagulants or high-dose/multiple doses NSAIDs. Based upon the available documentation, the request for omeprazole 20 mg is not supported and as such, was not medically necessary.