

Case Number:	CM14-0210672		
Date Assigned:	02/06/2015	Date of Injury:	10/05/2012
Decision Date:	04/03/2015	UR Denial Date:	11/11/2014
Priority:	Standard	Application Received:	12/16/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 48-year-old female, who sustained an industrial injury on 10/5/12. The 7/10/14 cervical MRI documented multilevel disc bulging with mild to moderate foraminal narrowing from C3/4 to C7/T1. The 7/10/14 right shoulder MRI impression documented prominent diffuse rotator cuff tendinopathy with focal distal supraspinatus tear, marked focal biceps tendinopathy with tenosynovitis, mild acromioclavicular joint degenerative arthritis, and type III acromion process, without evidence of impingement. The radiologist noted possible anterodistal supraspinatus calcification; x-ray confirmation was recommended. The 7/10/14 left shoulder MRI impression documented moderate supraspinatus tendinopathy with interstitial tears and no surface or full thickness rotator cuff tear or retraction. There was prominent proximal bicipital tendinopathy, and mild acromioclavicular joint capsular hypertrophy. Findings documented a type II acromion process with no significant lateral downsloping and preserved subacromial space. Records noted that the patient had been prescribed both topical and oral non-steroidal anti-inflammatory drugs (NSAID) on a long-term basis. She had previously been prescribed Naproxen Sodium which was changed to Nalfon on 9/25/14 to avoid sodium in light of her hypertension (185/104). Tramadol appeared to be prescribed and dispensed along with Norco since at least 7/23/14 with no documentation of a specific response. Records documented that a cervical traction unit was dispensed on 9/25/14 and a physiatry consult was to be scheduled. Records indicated that the patient had previously undergone left shoulder corticosteroid injection, but cortisone interfered with her anti-depressants and resulted in deep depression. The 10/23/14 treating physician report cited complaints of bilateral wrist pain, left

greater than right, and increased with movement. She had difficult gripping and grasping things, was unable to make a complete fist, and was dropping things. She used Norco and Tramadol for pain. Pain woke her at night. Objective findings documented limited and painful bilateral wrist range of motion with 1+ to 2+ edema bilaterally. The diagnoses included right shoulder impingement syndrome, multilevel cervical disc disease, bilateral carpal tunnel syndrome, and left shoulder impingement syndrome with moderate tendinopathy, biceps tendonitis, and acromioclavicular joint wear. The treatment plan included neck traction with air bladder, hot and cold wrap, left carpal tunnel release, left shoulder surgery with pre-operative testing, medications including Norco and Voltaren gel, physiatry consult for bilateral wrist pain, and right shoulder fluoroscopy and x-ray. The 11/10/14 utilization review non-certified the requests for Nalfon 400 mg. quantity 60, Tramadol 150 mg. quantity 30, fluoroscopic evaluation - right shoulder, physiatrist consultation, X-ray A/P lateral-right shoulder, cervical traction with air bladder, and arthroscopic decompression of the left shoulder with evaluation of biceps, biceps tendon release, stabilization, and distal clavicle excision. Medical Treatment Utilization Schedule Guidelines, American College of Occupational and Environmental Medicine and Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

arthroscopic decompression of the left shoulder with evaluation of biceps, biceps tendon release, stabilization, and distal clavicle excision between 10/28/14 and 4/26/15: 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): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for impingement syndrome; Partial claviclectomy.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, positive diagnostic injection, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have not been met. This patient presents with a history of left shoulder pain with non-specific findings of impingement. There is imaging evidence of supraspinatus and biceps tendinopathy with no full thickness rotator cuff tear or retraction and mild acromioclavicular joint capsule hypertrophy. There is no documentation of

range of motion, tenderness, strength or functional limitations in the current clinical records. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial (directed to the left shoulder) and failure has not been submitted. Therefore, this request is not medically necessary at this time.

cervical traction with air bladder between 10/28/14 and 4/26/15: 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 ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: Traction (mechanical).

Decision rationale: The California MTUS guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction. The Official Disability Guidelines recommend home cervical patient controlled traction (using a seated over-the-door device or a supine device, which may be preferred due to greater forces), for patients with radicular symptoms, in conjunction with a home exercise program. Records documented that a cervical traction unit was dispensed on 9/25/14. There is no compelling reason to support the medical necessity of an additional cervical traction unit. Therefore, this request is not medically necessary.

x-ray A/P lateral-right shoulder between 10/28/14 and 4/26/15: 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): 207-209.

Decision rationale: The California MTUS guidelines do not recommend the routine use of radiography for evaluation of shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. Guidelines state that cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral or acromioclavicular joints. Guideline criteria have not been met. The radiologist noted possible anterodistal supraspinatus calcification on MRI. Guidelines do not support additional imaging as the treatment plan would not be changed by confirmation of calcium deposits. Therefore, this request is not medically necessary.

physiatry consultation between 10/28/14 and 12/27/14: 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 American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition, Chapter 6, (Pain, Suffering, and the Restoration of Function), pg 109.

Decision rationale: The California MTUS does not specifically address physiatry referrals. The ACOEM guidelines states that the treatment of chronic pain requires specialized knowledge, substantial time, and access to multidisciplinary care. Judicious involvement of other professionals, including psychologists, exercise and physical therapists, and other healthcare professionals who can offer extra physical or mental therapy while the physician continues to orchestrate the whole therapeutic process can be helpful. Guideline criteria have not been met. This patient has been approved for a physiatry consult and records documented that scheduling was in process in September 2014. There is no compelling reason to support the medical necessity of an additional referral at this time. Therefore, this request is not medically necessary.

fluoroscopic evaluation - right shoulder between 10/28/14 and 1/25/15: 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): 207-209.

Decision rationale: The California MTUS guidelines do not recommend the use of fluoroscopy for shoulder evaluation. MRI was noted to be the preferred investigation for evaluation of soft tissue anatomy. Guideline criteria have not been met. There is no compelling reason to support the medical necessity of an additional imaging procedure. An MRI has been performed with no evidence that it was inconclusive regarding soft tissue anatomy. There is no evidence that this additional imaging would change the treatment plan. Therefore, this request is not medically necessary.

Tramadol 150 mg. #30 between 10/28/14 and 11/27/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Tramadol Page(s): 76-80, 93-94, 113.

Decision rationale: The California MTUS indicate that opioids are recommended for moderate to moderately severe pain. Tramadol is an opioid analgesic and is not recommended as a first line oral analgesic. If used on a long-term basis, the criteria for use of opioids should be followed. On-going management requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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. There

is no current pain assessment indicating the level of pain or what specific functional benefit has been achieved with the use of this medication. Tramadol has been prescribed with Norco since at least 7/23/14 with no documentation of objective functional benefit with use of this medication. Prior utilization reviews have noted recommendations and partial certifications for weaning. Therefore, this request is not medically necessary.

Nalfon 400 mg. #60 between 10/28/14 and 11/27/14: 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 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 Nalfon, are indicated for short term treatment for patients with moderate to severe pain from osteoarthritis. Non-steroidal anti-inflammatory drug guidelines warn of gastrointestinal symptoms and cardiovascular risks and generally recommend that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. Guideline criteria have not been met. There is no current documentation of a specific functional response to the use of NSAIDs with long term use and concomitant topical NSAID use noted. In light of this patient's significant hypertension, long term use, and no documentation of functional benefit, continued use is not supported by guidelines. Therefore, this request is not medically necessary.