

Case Number:	CM15-0109456		
Date Assigned:	06/16/2015	Date of Injury:	03/11/2012
Decision Date:	08/18/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/08/2015

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:

This injured worker is a 54-year-old female who sustained an industrial injury on 3/11/12. The mechanism of injury was not documented. Past surgical history was positive for right shoulder surgery on 10/9/12 and right shoulder arthroscopic revision subacromial decompression, distal clavicle resection, and extensive debridement of the labrum and rotator cuff on 10/23/14. Records indicated that the injured worker had been prescribed Ultracet 37.5/325 mg since at least 12/9/14 and Tylenol #4 since at least 11/11/14 with no discussion of pain relief or functional improvement noted in the subsequent progress reports. The 3/6/13 left shoulder MRI impression documented severe distal anterior supraspinatus tendinosis and bursal surface partial tear that extends into the substance of the tendon 50% of the thickness of the tendon. There was no through-and-through tear or retraction seen. There was a chronic-appearing SLAP lesion with detached biceps anchor. There was bursitis, moderate acromioclavicular (AC) arthrosis, and thickened coracoacromial ligament. The 5/4/15 treating physician report cited worsening left greater than right shoulder pain with more activity. Left shoulder exam documented abduction 116, internal rotation 23, external rotation 40, and flexion 121 degrees. The diagnosis was bilateral rotator cuff tears, right impingement syndrome, and rule-out cervical radiculopathy. The treating physician indicated that left shoulder had been approved but her right shoulder was still painful and needed revision first so she did not have two bad arms. The treatment plan recommended additional physical therapy. Authorization was requested for left shoulder surgery, Ultracet #30, Tylenol #4, and Naproxen 550 mg. The 5/26/15 utilization review non-certified the request for left shoulder surgery as the specific surgical request was not provided and records

indicated that the right revision surgery was opined as medically necessary before proceeding with left shoulder surgery. The request for Ultracet #30 was modified to Ultracet 37.5/325 mg #30 to allow an opportunity for submission of documentation of compliance with guidelines and the need for continuation. The request for Tylenol #4 was non-certified as there was no documentation as to why the injured worker required two short acting opioids. The request for Naproxen 550 mg was non-certified as there was no documentation of objective functional benefit with prior use of this medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

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: Surgery for Impingement syndrome; Surgery for rotator cuff repair.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery and rotator cuff surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome and partial thickness rotator cuff repairs 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, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement or rotator cuff deficiency. Guideline criteria have not been met. This injured worker presents with persistent left greater than right shoulder pain. Clinical findings were limited to range of motion which was restricted. Imaging documented a partial thickness rotator cuff tear and moderate AC arthrosis. Detailed evidence of 3 to 6 months a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the left shoulder and failure has not been submitted. There is no specific surgical procedure requested. Therefore, this request is not medically necessary at this time.

Ultracet #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments, Acetaminophen (APAP); Opioids for chronic pain; Opioids for neuropathic pain; Opioids, criteria for use, Therapeutic Trial of Opioids Page(s): 11-12, 80-82, 83.

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

Decision rationale: The California MTUS indicate that opioids, such as Ultracet (tramadol and acetaminophen), 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 prescriptions from a single practitioner taken as directed, all prescriptions from a single pharmacy, 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. Records indicate that this injured worker has been using Ultracet since at least 12/9/14 with no documentation of specific pain reduction or objective functional benefit. The 5/26/15 utilization review modified this request for Ultracet #30 to Ultracet 37.5/325 mg #30 consistent with prior prescription. There is no compelling rationale to support additional certification. Therefore, this request is not medically necessary.

Tylenol #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments, Acetaminophen (APAP); Opioids for chronic pain; Opioids for neuropathic pain; Opioids, criteria for use, Therapeutic Trial of Opioids Page(s): 11-12, 80-82, 83.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Opioids, specific drug list Page(s): 76-80, 92.

Decision rationale: The California MTUS guidelines support the use of Tylenol #4 up to every 4 hours with a maximum codeine dose of 360 mg/day and acetaminophen to 4000 mg/day. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. 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 the use of this medication in the absence of required documentation. There is no documentation of reduced pain, increased function, or improved quality of life relative to medication use in the progress reports or medical legal reports available for review. There is no documentation of on-going opioid therapy management. There is no compelling reason to support the medical necessity of a second opioid medication or an additional acetaminophen medication. Abrupt withdrawal of this medication is not recommended. However, the specific quantity being requested is not documented to allow for medical necessity to be established. Therefore, this request is not medically necessary.

Naproxen 550mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

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 Naproxen are indicated for short term lowest dosage treatment of symptoms associated with osteoarthritis and chronic back pain and as a second line option for acute exacerbations of chronic back pain. Guidelines indicate that there is no evidence of long-term effectiveness for pain or function. NSAIDs are recommended at the lowest dose for the shortest period of time for patients with moderate to severe pain from osteoarthritis. NSAIDs are recommended for short-term symptomatic relief in patients with chronic back pain. Records suggest that this is the initial prescription of Naproxen for this patient. A trial of this NSAID may be appropriate, however this request does not indicate the specific quantity being prescribed to establish medical necessity. Therefore, this request is not medically necessary.