

Case Number:	CM15-0131333		
Date Assigned:	07/17/2015	Date of Injury:	01/11/1984
Decision Date:	09/24/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	07/07/2015

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: Minnesota, Florida

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 75 year old male, who sustained an industrial injury on January 11, 1984. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having multilevel lumbar disc bulges from lumbar two through sacral one per magnetic resonance imaging, lumbar facet hypertrophy at lumbar five to sacral one with neuroforaminal stenosis and effacement of existing lumbar five nerve roots per magnetic resonance imaging, bilateral lumbar five lumbar radiculopathy per electromyogram, lumbar facet syndrome, status post bilateral total knee replacements, large tear of the rotator cuff with severe acromioclavicular joint arthrosis per magnetic resonance imaging, and chronic myofascial pain syndrome. Treatment and diagnostic studies to date has included magnetic resonance imaging of the right shoulder, magnetic resonance imaging of the lumbar spine, electromyogram, medication regimen, above noted procedure. In a progress note dated June 02, 2015 the treating physician reports complaints of constant pain to the right shoulder and the low back. Examination reveals severe tenderness to the right acromioclavicular joint, positive right shoulder rotator cuff sign, and decreased range of motion to the right shoulder and the lumbar spine, and positive hyperextension maneuver to the lumbar spine. The injured worker's medication regimen included Duragesic Patch, Protonix, Flexeril, and Relafen. The injured worker's pain level was rated a 7 to 9 out of 10 on a visual analog scale, but the documentation provided did not indicate the injured worker's pain level as rated on a pain scale prior to use of his medication regimen and after use of his medication regimen to indicate the effects with the use of the injured worker's medication regimen. Also, the documentation provided did not

indicate if the injured worker experienced any functional improvement with use of his medication regimen. The treating physician requested the medications of Protonix 20mg with a quantity of 60 for heartburn and gastrointestinal upset, Flexeril 7.5mg with a quantity of 60 for muscle spasm, and Relafen 750mg with a quantity of 120 to be used as needed noting current use of these medications. The treating physician requested magnetic resonance imaging of the lumbar spine to rule out lumbar spinal stenosis or hypertrophy. The treating physician also requested a right shoulder rotator cuff repair, debridement, synovectomy, resection acromioclavicular joint, and probable biceps tendinosis as recommended by a treating orthopedist.

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, debridement, synovectomy, resection AC joint probable biceps tendonitis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Rotator cuff tears, Reverse shoulder arthroplasty.

Decision rationale: The injured worker is a 75-year-old male with a date of injury of 1/11/1984. The current diagnoses include a chronic massive rotator cuff tear with severe acromioclavicular arthritis, chronic myofascial pain syndrome and low back pain. There is a request for Duragesic 25g, Protonix 20 mg, Flexeril 7.5 mg and Relafen 750 mg. Utilization review modified the request for Duragesic and noncertified the other requests. Per examination notes of 8/2/2015 there were positive rotator cuff signs in the right shoulder with tenderness over the acromioclavicular joint and restricted range of motion. There was restricted range of motion of the lumbar spine. A lumbar MRI study was requested to rule out spinal stenosis or hypertrophy. However, the prior lumbar MRI study was not submitted and the date of the prior MRI scan is not known. The guidelines recommend a repeat MRI with significant change in the clinical picture and/or findings suggestive of significant pathology such as tumor, infection, fracture, neuro compression, or recurrent disc herniation. An orthopedic note dated May 21, 2015 is reviewed. The diagnosis was a massive rotator cuff tear associated with glenohumeral arthritis and acromioclavicular arthritis. X-rays of the shoulder at that time revealed acromioclavicular arthrosis and early degenerative changes of the glenohumeral joint with a high riding humeral head. The provider suggested a workup of the medical issues including congestive heart failure prior to contemplating any type of surgery. With respect to the surgical options, the provider suggested attempted repair failing which he would be a candidate for reverse shoulder arthroplasty. The MRI scan of the right shoulder dated 4/13/2015 is submitted. The impression was a large transmural tear of the rotator cuff involving the supraspinatus and infraspinatus tendons with myotendinous retraction by approximately 3.5-4 cm. Marked muscle atrophy involving greater than 50% of the muscle volume. Type III acromion with moderate to severe

acromioclavicular arthrosis; non-visualization of the intra-articular long head biceps tendon; partial or complete disruption cannot be excluded; superior subluxation of the humeral head relative to the glenoid. The injured worker has a massive chronic rotator cuff tear with retraction and associated muscle atrophy which is said to be more than 50% of the muscle mass. There is a high riding humeral head with associated degenerative changes. As such, the tear is not reparable. ODG guidelines indicate insufficient evidence to suggest efficacy in operative or non-operative treatment of rotator cuff tears in patients aged older than 60 years. Even if the tear can be repaired, the re-tear rate is extremely high for large and massive rotator cuff tears particularly in older individuals. Furthermore, evidence of a recent comprehensive non-operative treatment protocol with exercise rehabilitation program and injections has not been submitted. Such non-operative treatment is also recommended by guidelines for biceps tenodesis as well as the requested partial claviclectomy. In light of the foregoing, the request for the right shoulder rotator cuff repair, debridement, synovectomy, resection of the acromioclavicular joint and probable biceps tenodesis is not supported and the medical necessity of the request has not been substantiated and therefore is not medically necessary.

Protonix 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs GI symptoms and cardiovascular risk: Proton Pump Inhibitors Page(s): 68.

Decision rationale: With regard to the request for Protonix, the California MTUS chronic pain guidelines do not recommend using non-steroidal anti-inflammatory drugs in the presence of a history of congestive heart failure. The orthopedic notes suggest such a history. As such, NSAIDs are contraindicated and proton pump inhibitors are therefore not necessary. In light of the above, the request for Protonix is not supported and the medical necessity of the request has not been substantiated and therefore is not medically necessary.

Flexeril 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

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

Decision rationale: California MTUS chronic pain treatment guidelines recommend muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine is recommended for a short course of therapy. Limited, mixed evidence does not allow for a recommendation for chronic use. As such, the request for cyclobenzaprine is not supported and the medical necessity of the request has not been substantiated and therefore is not medically necessary.

Relafen 750mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs: Hypertension and renal function Page(s): 69.

Decision rationale: California MTUS chronic pain treatment guidelines indicate NSAIDs can increase blood pressure by an average of 5-6 mm in patients with hypertension. They may cause fluid retention, edema, and rarely congestive heart failure. The risk appears to be higher in patients with congestive heart failure, kidney disease or liver disease. In this case, the documented history indicates the presence of congestive heart failure. As such, NSAIDs are contraindicated. The guidelines indicate oral opioids are an option for treatment in such patients; and therefore are not medically necessary.

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: California MTUS guidelines indicate MRI scan for the lumbar spine if physiologic evidence suggests tissue insult or nerve impingement to define a potential cause for and other soft tissue pathology. In this case the documentation suggests a prior MRI as well as EMG and nerve conduction study which showed evidence of L5 radiculopathy. However, the documentation does not suggest any worsening of neurologic function. The prior MRI report has not been submitted. As such a repeat MRI study without the benefit of the prior MRI report and without knowing the date of the prior MRI is not supported and therefore is not medically necessary.