

Case Number:	CM15-0050998		
Date Assigned:	03/27/2015	Date of Injury:	07/28/2014
Decision Date:	05/13/2015	UR Denial Date:	03/07/2015
Priority:	Standard	Application Received:	03/17/2015

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: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 55-year-old male who reported injury on 07/18/2014. The mechanism of injury was moving a banana box. Prior treatments include physical therapy and medications. The injured worker underwent a 3 view x-ray of the right shoulder on 07/31/2014 which revealed moderate glenohumeral degeneration. The injured worker underwent an MRI of the right shoulder on 10/06/2014 which revealed a flat acromion and osteoarthritis in the right acromioclavicular joint. The injured worker had a partial articular tear in the supraspinatus and partial thickness tear suscapularis. The injured worker had a SLAP type 2 of the glenoid labrum. The injured worker had a biceps tendon anchor tear with retraction of the horizontal segment and tendinosis of the vertical segment. There was a posterior superior subluxation of the humerus relative to the glenoid. There was synovial effusion. There was deltoid myositis in the subcorticoïd bursitis and irregular margins at the anterior aspect of the humeral head with concurrent ovoid subcortical defect in the posterior lateral aspect of the humeral head. The injured worker underwent urine drug screens. The documentation of 01/19/2015 revealed the injured worker had pain in the right neck and right shoulder that was increasing. The injured worker described the pain was increasing in his left shoulder as well. The injured worker had functional limitations. The physical examination revealed a positive Hawkins test and positive cross arm adduction test. There was tenderness to palpation over the posterior aspect of the shoulder. The injured worker had decreased range of motion of the shoulder. The motor strength was 4+/5 on the right and 4/5 on the right shoulder in flexion and abduction. There was diminished sensation in the bilateral L4-5 dermatomes of the lower extremities. The diagnoses

included disorder of bursae and tendons in the shoulder region unspecified. The treatment plan included orthopedic consultation, and medications including hydrocodone 10/325 mg, diclofenac XR 100 mg, omeprazole 20 mg, and cyclobenzaprine 7.5 mg as well as trazodone 50 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazadone hydrochloride (HCL) 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend antidepressants as a first line medication for the treatment of neuropathic pain. They are recommended especially if pain is accompanied by insomnia and anxiety or depression. The clinical documentation submitted for review indicated that the injured worker had neuropathic pain. However, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Trazadone hydrochloride (HCL) 50mg #60 is not medically necessary.

2 cortisone injections to the right shoulder, 1 to the subscapularius joint and 1 to the posterior shoulder capsule: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Steroid Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: The American College of Occupational and Environmental Medicine indicate that if pain with elevation significantly limits activities, subacromial injection of local anesthetic and corticosteroid preparation may be indicated after conservative therapy for 2 to 3 weeks. The clinical documentation submitted for review indicated the injured worker had objective functional limitations. The duration of conservative care was not provided. There was no specific physician documentation requesting the injections. Given the above, the request for 2 cortisone injections to the right shoulder, 1 to the subscapularius joint and 1 to the posterior shoulder capsule is not medically necessary.

Purchase of durable medical equipment (DME) transcutaneous electrical nerve stimulation (TENS) unit with conductive garment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

Decision rationale: The California Medical Treatment Utilization Schedule recommends a one month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The use of a conductive garment is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, that the patient has medical conditions that prevents the use of the traditional system, or the TENS unit is to be used under a cast. Clinical documentation failed to provide documentation of a trial and failure of other pain modalities. There was a lack of documented rationale for the request of a conductive garment. Additionally, there was a lack of documentation indicating the injured worker had a successful trial of the TENS unit with objective functional benefit and an objective decrease in pain. Given the above, Purchase of durable medical equipment (DME) transcutaneous electrical nerve stimulation (TENS) unit with conductive garment is not medically necessary.

Pantoprazole 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide documentation the injured worker had signs or symptoms of dyspepsia. The request as submitted failed to indicate frequency for the requested medication. Given the above, and the lack of documented efficacy the request for Pantoprazole 20mg #60 is not medically necessary.

Fenoprofen calcium 400mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend NSAIDs for the short term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain with the use of medication. The clinical documentation submitted for review indicated the

injured worker had utilized the medication for an extended duration of time. There is a lack of documentation of objective function improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Fenoprofen calcium 400mg #60 is not medically necessary.

Tramadol extended release (ER) 150mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, and objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had undergone urine drug screens. There is a lack of documentation of objective functional improvement and objective decrease in pain. There was of documentation indicating the injured worker was being monitored side effects. The request as it submitted failed to indicate the frequency for the request medication. Given the above, the request for Tramadol extended release (ER) 150mg #30 is not medically necessary.