

Case Number:	CM15-0080538		
Date Assigned:	07/06/2015	Date of Injury:	08/02/1999
Decision Date:	08/13/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	04/27/2015

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, Indiana, Oregon
 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 55-year-old female who sustained an industrial injury on 08/02/99. Initial diagnoses include unspecified myalgia and myositis, unspecified site of sacroiliac region sprain and strain, degeneration of lumbar or lumbosacral intervertebral disc, degeneration of cervical intervertebral disc, disorders of sacrum, lumbago, cervicgia, and spondylosis of unspecified site. In an orthopedic follow-up consultation report dated 03/13/15, the current diagnoses include right shoulder impingement with rotator cuff tendinopathy, cervical spondylosis, right lumbar radiculopathy, and rule out intradiscal component lumbar spine. Date of injury is shown as 04/23/12. The injured worker complains of bilateral shoulder, wrist, and hand pain. Physical examination is remarkable for tenderness of the right and left shoulder diffusely; there is limited range of motion. Diagnostic testing and treatment to date has included lumbar spine and right shoulder MRI, urine toxicology screening, pain medication management, TENS unit which significantly decreases the pain, and home exercise. Nonsteroidal anti-inflammatory medication for the shoulder with acid reducer has failed due to continued adverse gastric effects; she failed Celebrex. Trial of topical pain medication was successful, and Tramadol decreases the pain. Plan of care and treatment requests include right shoulder arthroscopic subacromial decompression, preoperative labs/EKG/history and physical, psychological consultation, Tramadol 50 mg #60 or Tramadol HCL ER 150 mg #30, Norco 10/325 mg # 6, Anaprox 550 mg # 60, Keflex 550 mg #28, and post-op physical therapy x12, 3x4 weeks, for the right shoulder. The injured worker's disability status is permanent and stationary. Date of Utilization Review: 04/17/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopic Subacromial Decompression: 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 Official Disability Guidelines (ODG) shoulder.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case, the exam notes from 3/13/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore, the request does not adhere to guideline recommendations and is not medically necessary.

Pre-op labs: 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 Official Disability Guidelines (ODG) shoulder.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-op EKG: 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 Official Disability Guidelines (ODG) shoulder.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Pre-op History and Physical: 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 Official Disability Guidelines (ODG) shoulder.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Psychologist consult: 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 Official Disability Guidelines (ODG) shoulder.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Norco 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 3/13/15. Therefore, the request is not medically necessary.

Tramadol 50mg #60 or Tramadol HCL ER 150mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines tramadol Page(s): 93-94.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence in the records of 3/13/15 of failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore, use of Tramadol is not medically necessary.

Anaprox 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines naproxen Page(s): 66.

Decision rationale: Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 66 states that Naproxen is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. It is used as first line treatment but long-term use is not warranted. In this case, the continued use of Naproxen is not warranted, as there is no demonstration of functional improvement from the exam note from 3/13/15. The requested treatment is not medically necessary.

Keflex 550mg #28: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Stulberg DL, Penrod MA, Blatny RA. Common bacterial skin infections. Am Fam Physician. 2002 Jul 1; 66(1):119-24.

Decision rationale: CA MTUS/ACOEM and ODG are silent on the issue of Keflex. An alternative guideline was utilized. According to the American Family Physician Journal, 2002 July 1; 66 (1): 119-125, titled "Common Bacterial Skin Infections," Keflex is often the drug of choice for skin wounds and skin infections. It was found from a review of the medical record submitted of no evidence of a wound infection to warrant antibiotic prophylaxis. The request for Keflex is therefore not medically necessary and appropriate.

Post-op physical therapy x12, 3x4 weeks, for the right shoulder: 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 Official Disability Guidelines (ODG) shoulder.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.