

<b>Case Number:</b>	CM15-0083282		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	11/02/2012
<b>Decision Date:</b>	06/03/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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 38 year old male, who sustained an industrial/work injury on 11/2/12. He reported initial complaints of a pop in the right shoulder. The injured worker was diagnosed as having right adhesive capsulitis of shoulder. Treatment to date has included medication, diagnostics, and surgery (s/p right shoulder surgery-Mumford procedure). MRI results were reported on 8/11/14 and demonstrated supraspinatus partial tendon tear, infraspinatus articular surface partial tendon tear, superior labral tear, SLAP type II configuration, posterior labral tear, cystic change of the posterior humeral head, healed incision. Currently, the injured worker complains of persistent and increasing right shoulder pain and stiffness radiating to his right arm and hand. Per the primary physician's progress report (PR-2) on 3/19/15, examination revealed a well healed surgical scar, tenderness to palpation over the anterolateral and posterosuperior aspects, positive impingement sign, limited range of motion to the right shoulder (flexion at 95 degrees, extension at 20 degrees, abduction at 80 degrees, adduction at 15 degrees, external rotation at 50 degrees, and internal rotation to 60 degrees). The postoperative arthrogram of the right shoulder on 8/12/14 is consistent with partial tears of the supraspinatus and infraspinatus tendons and a superior tear (SLAP type II). Diagnosis given was s/p right shoulder surgery with Mumford procedure, residual or recurrent internal derangement, right shoulder, and postoperative ankyloses of right shoulder. The requested treatments include right shoulder arthroscopy and Tramadol.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol 50mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 93.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines medical treatment 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 2/5/15 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.

**Right shoulder arthroscopy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**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, page 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 that is not present in the submitted clinical information from 2/5/15. 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 note from 2/5/15 does not demonstrate evidence satisfying the above criteria notably the failure of 6 months of continuous conservative care. Therefore, the determination is not medically necessary.