

Case Number:	CM15-0088480		
Date Assigned:	05/12/2015	Date of Injury:	05/13/2013
Decision Date:	06/12/2015	UR Denial Date:	04/23/2015
Priority:	Standard	Application Received:	05/08/2015

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: 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 69 year old female, who sustained an industrial injury on 05/13/2013. She has reported injury to the right shoulder, right knee, and low back. The diagnoses have included right shoulder tendinitis; status post right knee arthroscopy; and spondylolisthesis grade 2, L4-L5, with bilateral lower extremity radicular symptoms. Treatment to date has included medications, diagnostics, acupuncture, chiropractic, injection, physical therapy, and surgical intervention. Medications have included Ultracet and Gabapentin. A progress note from the treating physician, dated 03/23/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of ongoing pain to the right shoulder; lumbar spine pain with radiation to the right leg with numbness and tingling; difficulty walking and ambulates with a cane; and ongoing right knee pain and swelling. Objective findings included decreased range of motion of the thoracolumbar spine; decreased range of motion of the right shoulder with positive Hawkins and Neer's testing; tenderness to the right patellar region with positive McMurray's sign; and swelling noted on the right knee with scabbing over the entire joint. The treatment plan has included right shoulder arthroscopy with acromioplasty, possible Mumford procedure, and possible rotator cuff repair; Gabapentin 300 mg, #30 with 3 refills; and Ultracet, #60 with 3 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with acromioplasty, possible mumford procedure, and possible rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211, 210.

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. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case, the physical exam from 3/23/15 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the determination is not medically necessary.

Gabapentin 300mg, #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilipsy drugs Page(s): 18.

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and postherpetic neuralgia and is considered first line treatment for neuropathic pain. In this case, the exam note from 3/23/15 does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore, the request is not medically necessary.

Ultracet, #60 with 3 refills: 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), Pain - Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 87.

Decision rationale: CA MTUS Chronic pain guidelines, opioids page 87 states that the ongoing use of opioids for pain can be used with ongoing evidence of pain relief and functional benefit demonstrated by increasing work abilities or decreasing need for pain medications. The office visit of 3/23/15 does not clearly document the improvement in pain symptoms due to the medication or functional benefit as defined by the criteria. Based on the above the request is not medically necessary.