

Case Number:	CM14-0142091		
Date Assigned:	09/10/2014	Date of Injury:	05/10/2012
Decision Date:	11/26/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	09/02/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 60-year-old male who reported an injury on 05/10/2012. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of chronic rotator cuff tear right shoulder, frozen right shoulder, right shoulder status post arthroscopy, subacromial decompression, AC joint resection and failed rotator cuff repair, biceps tendon rupture to the right side, cervical strain, radiculitis, right upper extremity, and lumbar strain. Past medical treatment consists of physical therapy, injections, and medication therapy. No diagnostics were submitted for review. On 07/18/2014, the injured worker complained of right upper extremity pain. Physical examination revealed motor testing was 5/5 to all muscle groups in the upper extremities. Neurovascular status was intact. There was a positive Popeye deformity from the bicep rupture on the right shoulder. Negative Neer's test. Negative Hawkins test. Negative O'Brien's test. There was also negative crepitus. Resisted abduction strength was 4/5, to 30 degrees. Resisted external rotation strength was 4/5 to 10 degrees. Negative arm test drop. Treatment plan is for the continuation of medication therapy. The rationale was not submitted for review. The Request for Authorization form was submitted on 01/20/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL ER 150MG.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Ongoing management Page(s): 82, 93, 94, 113,78.

Decision rationale: The submitted documentation did not indicate the efficacy of the medication, nor did it indicate whether the medication was helping with any functional deficits. Additionally, there was no evidence of the injured worker having a diagnosis congruent with MTUS guidelines. The MTUS state that central analgesic drugs, such as tramadol, are reported to be effective in managing neuropathic pain. Furthermore, there were no drug tests or urinalysis submitted for review showing that the injured worker was compliant with prescription medications. Additionally, there was no assessment showing what pain levels were before, during and after medication administration. Given the above, the injured worker is not within MTUS recommended guidelines. As such, the request is not medically necessary.