

Case Number:	CM15-0128761		
Date Assigned:	07/15/2015	Date of Injury:	07/31/2014
Decision Date:	08/18/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/03/2015

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

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:

This 23 year old male sustained an industrial injury on 7/31/14. He subsequently reported shoulder pain. Diagnoses include right shoulder pain and capsular hypertrophy of the acromioclavicular joint. Treatments to date include MRI testing, injections and prescription pain medications. The injured worker continues to experience right shoulder pain. Upon examination, right shoulder range of motion is reduced. The AC joint is mildly tender. Greater tuberosity is mildly tender and proximal biceps is moderately tender. Impingement test was positive. A request for MRI of the Right Shoulder, Tramadol and Soma was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Chapter, under Magnetic resonance imaging (MRI).

Decision rationale: The patient presents with severe to 7/10 RIGHT shoulder pain radiating to RIGHT arm/hand and fingers. The request is for MRI OF THE RIGHT SHOULDER. The request for authorization is dated 05/19/15. X-ray of the RIGHT shoulder, 10/31/14, shows acromioclavicular joint arthritis of the right shoulder consider rotator cuff tear. MRI of the RIGHT upper extremity joint, 10/23/14, shows type II acromion with degenerative changes in the acromioclavicular joint; no evidence of rotator cuff or labral tear. X-ray of the RIGHT shoulder, 05/20/15, shows unremarkable RIGHT shoulder examination. Physical examination of the RIGHT shoulder reveals no bruising, swelling, atrophy, or lesion present. The ranges of motion are painful. Supraspinatus Press causes pain. He reports that the cortisone injection was beneficial. Patient's medications include Tramadol and Soma. Per progress report dated 07/07/15, the patient is temporarily totally disabled. ODG-TWC, Shoulder (Acute & Chronic) Chapter, under Magnetic resonance imaging (MRI) states: "Indications for imaging; Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs. Subacute shoulder pain, suspect instability/labral tear. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)" Per progress report dated 05/19/15, treater's reason for the request is "due to pain and weakness." Per progress report dated 07/07/15, treater also states, "RESPECTFULLY RE-REQUESTING MRI RIGHT SHOULDER FOR DIAGNOSTIC EVALUATION, AS PER [REDACTED] REQUEST." In this case, patient continues with pain of the RIGHT shoulder. Given the patients symptoms, ODG guidelines allows the use of MRI imaging to perform a global examination. However, review of medical records indicate a prior MRI of the RIGHT shoulder was performed on 10/23/14. Treater does not discuss any significant changes in symptoms to warrant an updated MRI. Therefore, the request IS NOT medically necessary.

Tramadol ER 100mg (Unspecified Quantity): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 88, 89, 76-78.

Decision rationale: The patient presents with severe to 7/10 RIGHT shoulder pain radiating to RIGHT arm/hand and fingers. The request is for TRAMADOL ER 100MG (UNSPECIFIED QUANTITY). The request for authorization is dated 05/19/15. X-ray of the RIGHT shoulder, 10/31/14, shows acromioclavicular joint arthritis of the right shoulder consider rotator cuff tear. MRI of the RIGHT upper extremity joint, 10/23/14, shows type II acromion with degenerative changes in the acromioclavicular joint; no evidence of rotator cuff or labral tear. X-ray of the RIGHT shoulder, 05/20/15, shows unremarkable RIGHT shoulder examination. Physical examination of the RIGHT shoulder reveals no bruising, swelling, atrophy, or lesion present. The ranges of motion are painful. Supraspinatus Press causes pain. He reports that the cortisone injection was beneficial. Patient's medications include Tramadol and Soma. Per progress report dated 07/07/15, the patient is temporarily totally disabled. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Treater does not specifically discuss this medication. The patient has been prescribed

Tramadol since at least 02/10/15. MTUS requires appropriate discussion of the 4A's, however, in addressing the 4A's, treater does not discuss how Tramadol significantly improves patient's activities of daily living with specific examples of ADL's. Analgesia is not discussed, specifically showing significant pain reduction with use of Tramadol. No validated instrument is used to show functional improvement. There is no documentation regarding side effects nor documentation regarding aberrant drug behavior. An inconsistent UDS, 03/24/15, was provided but no CURES or opioid pain contract. In this case, the 4A's have not been documented as required by MTUS. Therefore, given the lack of documentation as required by MTUS, the request IS NOT medically necessary.

Soma 350mg (Unspecified Quantity): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The patient presents with severe to 7/10 RIGHT shoulder pain radiating to RIGHT arm/hand and fingers. The request is for SOMA 350MG (UNSPECIFIED QUANTITY). The request for authorization is dated 05/19/15. X-ray of the RIGHT shoulder, 10/31/14, shows acromioclavicular joint arthritis of the right shoulder consider rotator cuff tear. MRI of the RIGHT upper extremity joint, 10/23/14, shows type II acromion with degenerative changes in the acromioclavicular joint; no evidence of rotator cuff or labral tear. X-ray of the RIGHT shoulder, 05/20/15, shows unremarkable RIGHT shoulder examination. Physical examination of the RIGHT shoulder reveals no bruising, swelling, atrophy, or lesion present. The ranges of motion are painful. Supraspinatus Press causes pain. He reports that the cortisone injection was beneficial. Patient's medications include Tramadol and Soma. Per progress report dated 07/07/15, the patient is temporarily totally disabled. MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects. Treater does not specifically discuss this medication. MTUS only recommends short-term use (no more than 2-3 weeks) for sedating muscle relaxants. However, patient has been prescribed Soma since at least 02/10/15. The request for additional Soma (unspecified quantity) does not indicate intended short-term use of this medication. Therefore, the request IS NOT medically necessary.