

Case Number:	CM15-0176775		
Date Assigned:	09/17/2015	Date of Injury:	04/03/2005
Decision Date:	11/09/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/08/2015

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 50 year old male, who sustained an industrial injury on 4-03-2005. The injured worker is being treated for bilateral shoulder tendinosis. Treatment to date has included medications, home exercise, physical therapy and injections. Per the Primary Treating Physician's Progress Report dated 7-14-2015, the injured worker reported chronic cervical pain, chronic low back pain, and bilateral shoulder pain. He has a history of bilateral rotator cuff tendinosis as well as impingement. His pain is rated as 9 out of 10. He has not has his medications since has missed his appointments. When he would take his medications, his pain would decrease to 6 out of 10. Objective findings included continued subacromial tenderness, and acromioclavicular joint tenderness to palpation. There is still subacromial swelling bilaterally which is 1+. Positive impingement signs are present. There is a negative drop arm test and negative apprehension sign. The only medical records submitted are from 1-22-2015 and 7-14-2015 and objective findings of the bilateral shoulders are identical. There are no diagnostics submitted for review including magnetic resonance imaging (MRI). Work status was temporary total disability. The plan of care included surgical intervention and authorization was requested on 8-26-2015 for right shoulder open decompression with possible rotator cuff repair, and medications including Ultracet, Flexeril, Neurontin, Prilosec and Fioricet. On 9-04-2015, Utilization Review non-certified the request for right shoulder open decompression with possible rotator cuff repair citing lack of appropriate supporting documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder Open Decompression with possible Rotator Repair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Work Loss Data Institute, www.odg-twc.com: Section: Shoulder (Acute & Chronic) updated 8/6/2015.

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 imaging is not provided to evidence rotator cuff tear. The request is not medically necessary.

Ultracet 37.5/325mg #90, thirty day supply with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid. 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 failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore, use of Tramadol is not medically necessary.

Flexeril 7.5mg #90, thirty day supply with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42 "Recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended." In this particular case the patient has no evidence in the records of functional improvement, a quantitative assessment on how this medication helps, percentage of relief lasts, increase in function, or increase in activity. Therefore, chronic usage is not supported by the guidelines. Therefore the request is not medically necessary.

Prilosec 20mg #60, thirty days supply with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines, page 68, recommendation for Prilosec is for patients with risk factors for gastrointestinal events. The cited records do not demonstrate that the patient is at risk for gastrointestinal events. Therefore, the request is not medically necessary.

Fioricet 50/325mg #60, thirty days supply with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Barbiturate-containing analgesic agents.

Decision rationale: CA MTUS chronic pain management, page 23, states that barbiturates are not recommended for chronic pain. The requested medicine contains barbiturate. Therefore this request is not medically necessary.