

Case Number:	CM15-0026691		
Date Assigned:	02/19/2015	Date of Injury:	09/28/2011
Decision Date:	04/01/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	02/12/2015

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: Illinois, California, Texas
 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 51-year-old female who sustained an industrial injury on 9/28/11, due to repetitive use. Past surgical history was positive for right shoulder arthroscopic subacromial decompression and debridement of the rotator cuff in September 2012. Records documented a right shoulder corticosteroid injection on 7/1/14 provided temporary relief. There is no evidence of recent physical therapy for the right shoulder. The 9/26/14 right shoulder MRI impression documented the previously seen full thickness rotator cuff tear had been surgically repaired. There was mild articular surface signal abnormality and probable partial tearing present in the anterior supraspinatus, without significantly unfavorable acromioclavicular joint or acromial morphology. The 11/18/14 treating physician report cited grade 5/10 right shoulder and cervical pain with right upper extremity symptoms. Low back pain was reported grade 5/10 with right lower extremity symptoms. Medications at current dosing allowed for maintenance of activities of daily living, participation in exercise and reasonable activities, and greater range of motion. Tramadol ER at 300 mg/day provided reduction in pain 6/10 with no side effects. Non-steroidal anti-inflammatory drugs (NSAIDs) reduced pain by 2-3/10. NSAIDs historically resulted in gastrointestinal upset without proton pump inhibit at current three time per day dosing. Failure of first-line omeprazole was documented. Physical exam documented right shoulder diffuse tenderness, deltoid atrophy, and limited range of motion. The treatment plan recommended chiropractic treatment for the left shoulder and continued conservative treatment right shoulder. The 1/6/15 treating physician report cited significant right shoulder pain in spite of conservative treatment, including corticosteroid injections. Right shoulder exam documented abduction 90,

forward flexion 90, and external/internal rotation 70 degrees, with positive impingement signs. The diagnosis was persistent impingement with rotator cuff tendinopathy, status post rotator cuff repair and acromioplasty. Medications were dispensed including Tramadol 150 mg #30 and Protonix 20 mg #90. On 2/5/15, utilization review non-certified requests for a repeat arthroscopic evaluation with further subacromial decompression of the right shoulder under anesthesia, pre-operative labs and electrocardiogram, post-operative physical therapy three times a week for four weeks for the right shoulder, Tramadol 150 mg # 30, Protonix 20mg # 60, Norco 10/325 mg # 60, Tramadol 50 mg # 60 or Tramadol HCL ER 150 mg, Anaprox 550 mg # 60 and Keflex. The MTUS, ACOEM Guidelines and Official Disability Guidelines, were cited. The rationale for non-certification of surgery and associated requests was based on failure to meet guideline criteria relative to subjective and objective findings. Opioid medication was denied as there was no evidence of a single prescribing physician, or guideline-recommended documentation relative to medication management. Protonix was non-certified based on no documentation of gastrointestinal issues, chronic anti-inflammatory use, and failure of first-line medications. On 2/12/15, the injured worker submitted an application for IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat arthroscopic evaluation with further subacromial decompression of the right shoulder under anesthesia: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have not been met. This patient presents with right shoulder pain with significant loss of range of motion and positive impingement tests. There is no documentation of specific localized tenderness or weakness. There is no clear imaging evidence suggestive of impingement. Detailed evidence of up to 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Pre-op labs and EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op physical therapy 3 x 4 for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Tramadol 150mg #30: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Tramadol Page(s): 76-80, 93-94, 113.

Decision rationale: The California MTUS indicate that opioids, such as Tramadol, are recommended for moderate to moderately severe pain. Tramadol is an opioid analgesic and is not recommended as a first line oral analgesic. If used on a long-term basis, the criteria for use of opioids should be followed. On-going management requires prescriptions from a single practitioner taken as directed, review and documentation of pain relief, functional status, appropriate medication use, and side effects. Guideline criteria have been met. The record reflects a single provider of medications with medication compliance, evidence of significant pain reduction and functional improvement, and no side effects. The patient was reported stable on the current dose. Therefore, this request is medically necessary.

Protonix 20mg #60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Proton pump inhibitors (PPIs).

Decision rationale: The California MTUS guidelines recommend the use of proton pump inhibitors (PPIs), such as omeprazole, for patients at risk for gastrointestinal events and for patients with dyspepsia due to NSAIDs use. The Official Disability Guidelines recommend the use of proton pump inhibitors for patients at risk for gastrointestinal events and indicate these medications should be used at the lowest dose for the shortest possible amount of time. Protonix is recommended as a second-line medication if a trial of omeprazole is not effective. Guideline criteria have been met. This patient has a history of gastrointestinal upset relative to NSAIDs use which has been well-controlled with Protonix following a failed trial of omeprazole. Therefore, this request is medically necessary.

Norco 10/325mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Opioids.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Tramadol 50mg #60 or Tramadol HCL ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Anaprox 550mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-72.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) guidelines state non-steroidal anti-inflammatory drugs (NSAID), such as Anaprox, are indicated for patients with moderate to severe pain from osteoarthritis and chronic low back pain. This patient presents with moderate neck, back, and right shoulder pain. Benefit has been documented with the use of this medication, both in objective terms of pain reduction and functional improvement. Therefore, this request is medically necessary at this time.

Kelfex: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.