

Case Number:	CM15-0095878		
Date Assigned:	05/22/2015	Date of Injury:	01/15/2014
Decision Date:	06/26/2015	UR Denial Date:	05/07/2015
Priority:	Standard	Application Received:	05/18/2015

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: Emergency Medicine

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 59 year old male, who sustained an industrial injury on 1/15/14. He reported initial complaints of right upper extremity including right shoulder. The injured worker was diagnosed as having pain in joint, shoulder region; unspecified disorder of bursa and tendons in shoulder region. Treatment to date has included status post right shoulder rotator cuff reconstruction (4/30/14); status post revision right rotator cuff reconstruction (5/2/14); physical therapy; medications. Diagnostics included X-rays to right shoulder (5/29/14 and 1/12/15). Currently, the PR-2 notes dated 10/30/14 indicated the injured worker complains of pain in the bilateral shoulders with the right greater than the left. He is a status post right shoulder rotator cuff reconstruction of 4/30/14 with revision on 5/2/14. At the time, the supraspinatus was noted to be insufficient. He has been working in therapy and has been working at home. He is doing better but still has intermittent symptoms 6 months out from his surgery. The left shoulder has forward flexion abduction impingement with ongoing pain. On physical examination the right shoulder can elevate to 170 with his external rotation to 70 and internal rotation to 50. He has weakness to abduction on the right side and mildly to external rotation. He has poor scapulothoracic motion on the right. The wounds are clean and dry with crepitus and forward flexion impingement; there is no winging. The left shoulder has range of motion to 180, abduction to 180, external rotation to 70, and internal rotation to 70. He has 4+/5 abduction external rotation strength with weakness to the supraspinatus but not external rotation on the left side. X-rays to right shoulder were completed on 1/12/15 which noted glenohumeral and acromioclavicular osteoarthritis. Notes indicated the injured worker is awaiting the left shoulder

surgery. The provider is requesting: Physical Therapy 2 x 6 to Right Shoulder; Keratek 4 oz.; Ultram 50mg #60 and Norco 10/325mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x 6 to Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical therapy, Sprained Shoulder; rotator cuff.

Decision rationale: The requested Physical Therapy 2 x 6 to Right Shoulder is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Shoulder Complaints, Summary of Recommendations and Evidence, page 212; and Official Disability Guidelines (ODG), Shoulder, Physical therapy, Sprained Shoulder; rotator cuff; recommend up to 10 physical therapy sessions for this condition and continued therapy with documented objective evidence of derived functional improvement. The injured worker has pain in the bilateral shoulders with the right greater than the left. He is a status post right shoulder rotator cuff reconstruction of 4/30/14 with revision on 5/2/14. At the time, the supraspinatus was noted to be insufficient. He has been working in therapy and has been working at home. He is doing better but still has intermittent symptoms 6 months out from his surgery. The left shoulder has forward flexion abduction impingement with ongoing pain. On physical examination, the right shoulder can elevate to 170 with his external rotation to 70 and internal rotation to 50. He has weakness to abduction on the right side and mildly to external rotation. He has poor scapulothoracic motion on the right. The wounds are clean and dry with crepitus and forward flexion impingement; there is no winging. The left shoulder has range of motion to 180, abduction to 180, external rotation to 70, and internal rotation to 70. He has 4+/5 abduction external rotation strength with weakness to the supraspinatus but not external rotation on the left side. The treating physician did not document objective evidence of derived functional improvement from completed physical therapy sessions. Finally, the completed therapy sessions should have afforded sufficient time for instruction and supervision of a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical Therapy 2 x 6 to Right Shoulder, is not medically necessary.

Keratek 4 oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The requested Keratek 4 oz , is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has pain in the bilateral shoulders with the right greater than the left. He is a status post right shoulder rotator cuff reconstruction of 4/30/14 with revision on 5/2/14. At the time, the supraspinatus was noted to be insufficient. He has been working in therapy and has been working at home. He is doing better but still has intermittent symptoms 6 months out from his surgery. The left shoulder has forward flexion abduction impingement with ongoing pain. On physical examination, the right shoulder can elevate to 170 with his external rotation to 70 and internal rotation to 50. He has weakness to abduction on the right side and mildly to external rotation. He has poor scapulothoracic motion on the right. The wounds are clean and dry with crepitus and forward flexion impingement; there is no winging. The left shoulder has range of motion to 180, abduction to 180, external rotation to 70, and internal rotation to 70. He has 4+/5 abduction external rotation strength with weakness to the supraspinatus but not external rotation on the left side. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Keratek 4 oz, is not medically necessary.

Ultram 50mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, and Tramadol, Page 113 Page(s): 78-82, 113.

Decision rationale: The requested Ultram 50mg, #60, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, and Tramadol, Page 113, do not recommend this synthetic opioid as first-line therapy, and recommend continued use of opiates for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has pain in the bilateral shoulders with the right greater than the left. He is a status post right shoulder rotator cuff reconstruction of 4/30/14 with revision on 5/2/14. At the time, the supraspinatus was noted to be insufficient. He has been working in therapy and has been working at home. He is doing better but still has intermittent symptoms 6 months out from his surgery. The left shoulder has forward flexion abduction impingement with ongoing pain. On physical examination, the right shoulder can elevate to 170 with his external rotation to 70 and internal rotation to 50. He has weakness to abduction on the right side and mildly to external rotation. He has poor scapulothoracic motion on the right. The wounds are clean and dry with crepitus and forward flexion impingement;

there is no winging. The left shoulder has range of motion to 180, abduction to 180, external rotation to 70, and internal rotation to 70. He has 4+/5 abduction external rotation strength with weakness to the supraspinatus but not external rotation on the left side. The treating physician has not documented: failed first-line opiate trials, VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract nor urine drug screening. The criteria noted above not having been met, Ultram 50mg, #60, is not medically necessary.

Norco 10/325mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

Decision rationale: The requested Norco 10/325mg, #90, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has pain in the bilateral shoulders with the right greater than the left. He is a status post right shoulder rotator cuff reconstruction of 4/30/14 with revision on 5/2/14. At the time, the supraspinatus was noted to be insufficient. He has been working in therapy and has been working at home. He is doing better but still has intermittent symptoms 6 months out from his surgery. The left shoulder has forward flexion abduction impingement with ongoing pain. On physical examination, the right shoulder can elevate to 170 with his external rotation to 70 and internal rotation to 50. He has weakness to abduction on the right side and mildly to external rotation. He has poor scapulothoracic motion on the right. The wounds are clean and dry with crepitus and forward flexion impingement; there is no winging. The left shoulder has range of motion to 180, abduction to 180, external rotation to 70, and internal rotation to 70. He has 4+/5 abduction external rotation strength with weakness to the supraspinatus but not external rotation on the left side. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Norco 10/325mg, #90, is not medically necessary.