

Case Number:	CM14-0013076		
Date Assigned:	02/24/2014	Date of Injury:	03/09/2011
Decision Date:	08/11/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/31/2014

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 and 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 patient is a 31-year-old male who has filed a claim for left shoulder osteoarthropathy and effusion associated with an industrial injury date of March 09, 2011. Review of progress notes indicates left shoulder pain and decreased ability to sleep. Findings include decreased range of motion, tenderness over AC joints, positive impingement, and decreased strength of bilateral shoulders. Examination of the cervical spine showed tenderness over the upper trapezius and decreased range of motion due to pain. MRI of the cervical spine dated August 06, 2013 showed early disc desiccation; and multilevel disc protrusions effacing the thecal sac with narrowing of the left C5-6 neuroforamen, effacing the left C6 exiting nerve root. MRI of the left shoulder showed osteoarthropathy of the AC joint, and minimal glenohumeral joint effusion. MRI of the right shoulder showed osteoarthritis and capsulitis at the AC joint, and partial tear of the supraspinatus tendon. Electrodiagnostic report dated August 19, 2013 was normal. Treatment to date has included NSAIDs, muscle relaxants, opioids, physical therapy, acupuncture, and chiropractic therapy. Utilization review from January 06, 2014 denied the requests for acupuncture x 12 left shoulder as there was no documentation regarding the previous acupuncture sessions; psychological consult as there was lack of detailed documentation regarding the patient's report of stress and anxiety; supervised functional restoration program 2x6 as the patient has failed all available conservative treatment; and range of motion strength testing as there are no studies to support this. There was modified certification for cyclobenzaprine 10mg for #20 to initiate downward titration as this medication is not recommended for long-term use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 10MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state that cyclobenzaprine is a skeletal muscle relaxant and a CNS depressant that is recommended as a short-course therapy. The effect is greatest in the first 4 days of treatment. Patient has been on this medication since October 2013. There is no documentation of acute exacerbation of pain or significant muscle spasms to support the continued use of this medication. Therefore, the request for cyclobenzaprine 10mg #30 was not medically necessary.

Acupuncture X12 Left Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function chapter, page 114.

Decision rationale: As noted on page 114 of the California MTUS ACOEM Guidelines, they stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. In addition, Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Functional improvement should be observed within 3-6 treatments, with treatments rendered 1 to 3 times per week and an optimum duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. In this case, there is mention that the patient has received previous acupuncture therapy. However, there is no documentation describing the previous sessions, including the objective functional benefits derived. Additional information is necessary at this time to support this request. Therefore, the request for acupuncture x 12 left shoulder was not medically necessary.

Psychological Consult: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations chapter, pages 127 and 156.

Decision rationale: As stated on pages 127 and 156 of the ACOEM Independent Medical Examinations and Consultations Guidelines referenced by California MTUS, occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. In this case, the recent progress notes do not document psychological complaints, or decreased functioning due to significant psychological symptoms. There is only mention of decreased ability to sleep. There is no indication for a psychological consult at this time. Therefore, the request for psychological consult was not medically necessary.

Supervised Functional Restoration Program 2X6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-32.

Decision rationale: According to pages 30-32 of the California MTUS Chronic Pain Medical Treatment Guidelines, functional restoration programs are recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk for delayed recovery. Patients should be motivated to improve and return to work. Criteria for use of multidisciplinary pain management programs include an adequate and thorough multidisciplinary evaluation has been made, unsuccessful attempts with conservative treatment options, significant loss of ability to function independently due to the chronic pain, and the patient is not a surgical candidate. Negative predictors of success include a negative relationship with the employer, poor work adjustment and satisfaction, negative outlook about future employment, high levels of psychosocial distress, involvement in financial disability disputes, greater rates of smoking, duration of pre-referral disability time, prevalence of opioid use, and pre-treatment levels of pain. In this case, there is no documentation of failure of all conservative management options as the patient is on medications, and still being prescribed physical therapeutic modalities. Also, there is no documentation regarding a thorough multidisciplinary evaluation or of the significant loss of ability to function independently. The patient is allowed to work with modified duty. Therefore, the request for supervised functional restoration program 2x6 was not medically necessary.

Range of Motion Strength Testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back chapter, Flexibility; Knee and Leg Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, Flexibility; Knee and Leg chapter, Computerized muscle testing; Shoulder chapter, Range of motion.

Decision rationale: The California MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, range of motion should always be examined in cases of shoulder pain. Flexibility should be part of a routine musculoskeletal evaluation. Regarding strength testing, computerized muscle testing is not recommended. There are no studies to support computerized strength testing for the extremities. In this case, there is no documentation as to the necessity of a specialized range of motion strength testing over a thorough physical examination. Therefore, the request for range of motion strength testing was not medically necessary.