

Case Number:	CM14-0137299		
Date Assigned:	10/14/2014	Date of Injury:	05/30/2011
Decision Date:	11/13/2014	UR Denial Date:	08/11/2014
Priority:	Standard	Application Received:	08/25/2014

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 Orthopedic Surgery 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:

This 44-year-old female medical service worker sustained an industrial injury on 5/30/11, relative to a cumulative trauma. The patient denied any significant past medical history. Initial exam for this injury was reported on 4/14/14. A prior orthopedic evaluation was noted on 6/2/14 with a corticosteroid injection for the neck and left shoulder. She was prescribed Ultram and gabapentin. Chiropractic treatment was documented as on-going since 2012, with the most recent visit on 7/23/14 and follow-up scheduled on 7/31/14. The 7/31/14 initial orthopedic report indicated that the patient presented for orthopedic evaluation but that x-rays and MRI results were not available. Subjective complaints included constant grade 8/10 left shoulder pain radiating to the left arm intermittently, and weakness. She was unable to reach overhead or sleep on the left shoulder. Pain was improved with ice, heat, and medications. Pain was worse with typing, talking on the telephone, lifting, reaching overhead, sleeping on this shoulder, and sudden movements. Functional difficulty was noted in activities of daily living. Current medications included Ultram 50 mg once daily, gabapentin 400 mg once daily, and Naproxen 500 mg twice daily. Left shoulder range of motion testing documented abduction 50, flexion 90, external rotation 90, internal rotation 50, and extension 15 degrees. There was 4/5 abduction strength, 5/5 external and internal rotation strength, and positive impingement, Hawkin's and Speed's tests. Cross arm and O'Brien's tests were positive. There was tenderness over the rotator cuff, biceps tendon, acromioclavicular joint and posterior capsule on the left. Cervical range of motion was mildly limited with tenderness over the cervical paraspinals, left trapezius and shoulder girdle. The diagnosis was left frozen shoulder with rotator cuff strain, bicipital tendinitis, and acromioclavicular joint inflammation, and discogenic cervical condition with facet inflammation without radiculopathy. The treatment plan recommended arthroscopic decompression, lysis of adhesions of the left shoulder, but noted that the MRI report was needed before surgery.

Following surgery, she would need 24 sessions of aggressive therapy. In the meantime, she could do chiropractic 12 sessions. Medications were prescribed including Ultram 50 mg #60, Naproxen 550 mg #60, Protonix 20 mg #60 to protect the stomach, Arnicare topical lotion, and Flexeril 7.5 mg #60. The patient was working 4 hours a day with work restrictions outlined. The 8/11/14 utilization review denied the left shoulder arthroscopy and associated physical therapy as there was no evidence of 3 to 6 months of recent failed conservative treatment. The request for 12 visits of chiropractic treatment was modified to 6 visits for an initial trial consistent with guidelines. The request for Ultram 50 mg #60 was denied as there was no evidence that the patient had failed a trial of non-opioid analgesics. The request for Arnicare topical gel was denied due to lack of guideline evidence for support. Protonix was non-certified as there was no documented history of gastroesophageal reflux disease to support use. The request for Flexeril 7.5 mg #60 was modified to #30 as there was no guideline support for use beyond 2 to 3 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Arthroscopy decompression, lysis of adhesion's on the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211; 214.

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 of adhesive capsulitis, 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 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, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement. Guidelines state there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment, including physical therapy and non-steroidal anti-inflammatory drugs (NSAIDs). Guideline criteria have not been met. There is no current imaging evidence of impingement documented. There is no documentation of a positive diagnostic injection test. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including physical therapy and NSAIDs, and failure has not been submitted. Therefore, this request is not medically necessary.

24 aggressive therapy sessions: 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.

12 chiropractic sessions: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 9, 58.

Decision rationale: The California MTUS guidelines generally support the use of manual therapy and manipulation for the treatment of chronic pain caused by musculoskeletal conditions. MTUS physical medicine guidelines state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. The ACOEM guidelines state that manipulation by a manual therapist may be effective for patients with frozen shoulders, but the period of treatment is limited to a few weeks because results decrease with time. Guideline criteria have not been met. Records indicate that the patient has been under chiropractic treatment for 2 years, with recent and continuing care documented. There is no documentation of functional improvement with chiropractic treatment to date. The 8/11/14 utilization review modified the request for 12 visits of chiropractic treatment to 6 visits for a trial. There is no compelling reason to support the medical necessity of additional chiropractic treatment prior to documentation of an objective measurable functional benefit. Therefore, this request is not medically necessary.

Ultram 50mg, qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212.

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 Ultram, are recommended for moderate to moderately severe pain. Ultram 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, all prescriptions from a single pharmacy, review and documentation of pain relief, functional status, appropriate medication use, and side effects. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Guideline criteria have not been met. Records

suggest that the use of this medication was initiated in June 2014 with no documentation of any pain or functional benefit. There is no evidence that first-line analgesics had been trialed and had failed. Therefore, this request is not medically necessary.

Arnicare topical (Unknown prescription): Upheld

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 Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Cervical and thoracic spine disorders. In: Hegmann KT, editor(s). Occupational medicine practice guidelines. Evaluation and management of common health problems and functional recovery in workers. 3rd ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2011. p. 1-332

Decision rationale: Arnicare topical gel contains the active ingredient arnica montana. The California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The revised 2011 ACOEM cervical and thoracic guidelines indicate that arnica is an option in the treatment of chronic cervicothoracic pain. Although the use of Arnicare may be supported in the treatment of chronic cervicothoracic pain, this request does not provide specific directions for use or a prescribed quantity. Medical necessity cannot be established without complete prescribing information. Therefore, this request is not medically necessary.

Protonix 20mg, qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

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. Risk factors include age greater than 65 years, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The Official Disability Guidelines recommend Protonix as a second-line medication if a trial of omeprazole is not effective. Guideline criteria for have not been met. The patient has been prescribed an NSAID but there is no evidence to suggest that this patient is at risk for gastrointestinal events. There is no documentation that omeprazole has been trialed and failed. Therefore, this request is not medically necessary.

Flexeril 7.5mg, qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181, Chronic Pain Treatment Guidelines Muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Muscle relaxants (for pain) Page(s): 41-42, 63-65.

Decision rationale: The California MTUS guidelines recommend the use of cyclobenzaprine (Flexeril) as an option, using a short course of therapy, in the management of back pain. Treatment should be brief. This medication is not recommended to be used for longer than 2 to 3 weeks. The 8/11/14 utilization review modified the request for Flexeril 7.5 mg #60 to #30 as there was no guideline support for use beyond 2 to 3 weeks. There is no compelling reason to support the medical necessity of additional Flexeril in the absence of guideline support. Therefore, this request is not medically necessary.