

Case Number:	CM14-0181271		
Date Assigned:	11/07/2014	Date of Injury:	01/27/2010
Decision Date:	12/11/2014	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/30/2014

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, has a subspecialty in Hand Surgery and is licensed to practice in Texas. 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 injured worker is a 48-year-old female who reported an injury on 09/01/2002 due to an unknown mechanism. Diagnoses were cervical spine strain, thoracic spine strain, status post right shoulder surgery, status post left shoulder surgery, right elbow strain, status post left elbow surgeries, status post right carpal tunnel release surgery, and status post left carpal tunnel syndrome. Past treatments and diagnostic studies were not reported. Physical examination on 09/16/2014 revealed no new numbness or tingling. There were complaints from the injured worker of pain in the neck, upper back, right shoulder, left shoulder, right and left elbow, right and left wrist. Examination revealed diminished sensation in the right thumb tip, the right long tip, and the right small tip. The treatment plan was for medications, shockwave therapy once a week for 6 weeks, physical therapy once a week for 8 weeks and a visit with an orthopedist for left shoulder injection. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motrin 800mg #90 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatories, Ibuprofen Page(s): 22.

Decision rationale: The request for Motrin 800mg #90 with 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule states anti-inflammatories are the "first line of treatment, to reduce pain so activity and functional restoration can resume, but long term use may not be warranted." Objective decrease in pain, and objective include in function should be documented. There was no VAS pain scores reported for the injured worker. There is a lack of documentation of objective functional improvement from the use of this medication. Furthermore, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Soma 340mg 330 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29, 65.

Decision rationale: The request for Soma 340mg 330 with 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule states that Soma (Carisoprodol) is "not indicated for longer than a 2 to 3 week period." Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. Tapering should be individualized for each patient. The medical guidelines do not support the use of this medication for longer than a 2 to 3 week period. There is a lack of documentation of objective functional improvement from the use of this medication. Also, the request does not indicate a frequency for the medication. There was no significant functional benefit resulting from the use of this medication reported. Therefore, this request is not medically necessary.

Tramadol 50mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram), Ongoing Management Page(s): 82, 93, 94, 113, 78.

Decision rationale: The request for Tramadol 50mg #60 with 2 refills is not medically necessary. California MTUS states Central analgesics drugs such as Tramadol (Ultram) are "reported to be effective in managing neuropathic pain and it is not recommended as a first-line oral analgesic." California MTUS recommend that there should be documentation of the 4 A's for Ongoing Monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. There is a lack of an objective assessment of the injured worker's

pain level, functional status, evaluation of risk for aberrant drug abuse behavior and side effects. Furthermore, the request does not indicate a frequency for the medication. The request is not medically necessary.

Shockwave Therapy Once a Week for 6 Weeks (Cervical): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Extracorporeal Shock Wave Therapy

Decision rationale: The request for Shockwave Therapy once a week for 6 weeks (cervical) is not medically necessary. The decision for extracorporeal shockwave therapy sessions is not medically necessary. The Official Disability Guidelines state that it is "not recommended." The available evidence does not support the effectiveness of ultrasound or shockwave for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. The guidelines do not support the use of extracorporeal shockwave therapy. Therefore, the request is not medically necessary.

Physical Therapy Once a Week for 8 Weeks (Cervical/Bilateral Shoulders): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98.

Decision rationale: The request for Physical Therapy Once a Week for 8 Weeks (Cervical/Bilateral Shoulders) is not medically necessary. The California MTUS state that active therapy is "based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort." Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There was a lack of documentation indicating the injured workers prior course of physical therapy as well as the efficacy of the prior therapy. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Therefore, this request is not medically necessary.

Follow-Up Evaluation with an Orthopedist (Left Shoulder Injection): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office Visit

Decision rationale: The request for Follow-Up Evaluation with an Orthopedist (Left Shoulder Injection) is not medically necessary. The Official Disability Guidelines recommend office visits for proper diagnosis and return to function of an injured worker. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the injured worker's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As injured workers' conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best injured worker outcomes are achieved with the eventual injured worker independence from the healthcare system through self-care as soon as clinically feasible. There is a lack of documentation of conservative care, pain level and functional deficits. The clinical information submitted for review does not provide evidence to justify a follow-up visit with an orthopedist. Therefore, this request is not medically necessary.

Follow-Up Evaluation with an Orthopedist (Left Shoulder): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office visit

Decision rationale: The request for follow-up evaluation with an orthopedist (left shoulder) is not medically necessary. The Official Disability Guidelines recommend office visits for proper diagnosis and return to function of an injured worker. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the injured worker's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As injured workers' conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best injured worker outcomes are achieved with the eventual injured worker independence from the healthcare system through self-care as soon as clinically feasible. There is a lack of documentation of conservative care, pain level and functional deficits. The clinical information submitted for review does not provide evidence to justify a follow-up visit with an orthopedist. Therefore, this request is not medically necessary.