

<b>Case Number:</b>	CM14-0183026		
<b>Date Assigned:</b>	11/07/2014	<b>Date of Injury:</b>	09/14/1999
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2014

### 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 & Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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 63 year old male with an injury date of 09/14/99. Based on the progress report dated 10/02/14, the patient complains of left shoulder pain and lower back pain that radiates to bilateral lower extremities. The pain is rated at 6-9/10. The sharp, stabbing, intense, excruciating, and unbearable pain in lower back and lower extremities worsens with bending and reaching. Physical examination reveals severe pain in the left shoulder with flexion and extension. There is tenderness along acromioclavicular joint, sternoclavicular joints, subacromial bursa, deltoid bursa, biceps tendon, suprascapular region, and the periscapular muscle. The shoulder range of motion is severely limited. Deep tendon reflexes are 1/4 at bilateral biceps, brachioradialis, and triceps tendons. Physical examination of the lumbar spine reveals tenderness at L4-5 and L5-S1 facet joints and sacroiliac joint. The patient has relied on ice/heat, stretching and physical therapy to manage the pain, as per progress report dated 10/02/14. He also uses braces and Hydrocodone. The patient is not keen on any type of invasive therapy, as per the same progress report. At work, the patient has been on modified duty, as per progress report dated 08/29/14. MRI of the Left Shoulder, 09/19/14:- Small amount fluid surrounding the long head of the biceps consistent with tenosynovitis- Fluid surrounding the subscapularis tendon - Tendinosis of the supraspinatus muscle as a result of chronic impingement X-ray of the Left Shoulder, as per progress report dated 05/13/14: Mild indication of AC joint arthritis. Diagnosis, 10/02/14- Left shoulder arthropathy; bursitis- Left shoulder adhesive capsulitis- Left shoulder impingement- Lumbago- Lumbar disc bulges- Lumbar facet joint pain- Sacroiliac joint pain The treater is requesting for X-RAY. The utilization review determination being challenged is dated 10/03/14. The Utilization Review Denial Letter does not provide a specific rationale for the denial. Treatment reports were provided from 05/13/14 - 10/02/14.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **6 visits of physical therapy:** 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 Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** This patient presents with left shoulder and low back pain. Treater is requesting 6 additional physical therapy sessions. For physical medicine, the MTUS Guidelines page 98 and 99 recommends for myalgia, myositis-type symptoms 9 to 10 sessions over 8 weeks. Review of the medical file indicates the patient received 6 physical therapy sessions between 05/13/2014 and 08/12/2014. Physical therapy treatment reports were not provided for review. In this case, the treater's request for 6 additional sessions with the 6 already received exceeds what is recommended by MTUS. Furthermore, the treater does not discuss why the patient will not be able to transition into a self-directed home exercise program. Recommendation is for denial.

### **MRI (magnetic resonance imaging) of the lumbar spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, MRI's (magnetic resonance imaging)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, MRIs (magnetic resonance imaging)

**Decision rationale:** This patient present with left shoulder and low back pain. This is a request for MRI (magnetic resonance imaging) of the lumbar spine. Utilization review denied the request stating that there is no "clear-cut neurological findings related to the lumbar spine that would necessitate an MRI of the lumbar spine." For special diagnostics, ACOEM Guidelines page 303 states "unequivocal objective findings that identify specific nerve compromise on the neurological examination is sufficient evidence to warrant imaging in patients who do not respond well to treatment and who would consider surgery as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." For this patient's now chronic condition with radicular symptoms and weakness, ODG guidelines provide a good discussion. ODG under its low back chapter recommends obtaining an MRI for uncomplicated low back pain with radiculopathy after 1 month of conservative therapy, sooner if severe or progressive neurologic deficit. The medical file provided for review does not include prior MRI imaging. No MRI reports were found, no reference to an MRI in any of the reports. Given the patient's complaints

of continued pain and radicular symptoms, an MRI for further investigation is within the guidelines. Recommendation is for approval.

**Hydrocodone 10/325mg, #120, 1 every six hours as needed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use for a therapeutic trial of opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; criteria for use of opioids Page(s): 60,61;76-78;88-89.

**Decision rationale:** This patient presents with left shoulder and low back pain. The treater is requesting hydrocodone 10/325 mg #120, 1 every 6 hour as needed. The MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. Review of medical file indicates the patient has been utilizing hydrocodone since at least 09/02/014. In this case, recommendation for further use cannot be supported as the treater does not provide specific functional improvement or changes in ADLs with this medication. The treater has provided a pain scale to denote the patient's current pain but no before and after scales are provided to show analgesia. It was noted the patient is currently working with work restrictions, but the treater does not discuss any change in work status to show significant functional improvement. Furthermore, treater does not discuss adverse side effects or aberrant behaviors and urine toxicology screens and CURES report are not discussed. Given the lack of sufficient documentation demonstrating efficacy for chronic opiate use, the patient should now slowly be weaned as outlined in MTUS Guidelines. Recommendation is for denial.

**Lumbar support brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, lumbar supports

**Decision rationale:** This patient presents with left shoulder and low back pain. Treater is requesting a lumbar support brace. ACOEM Guidelines page 301 on lumbar bracing state, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under its Low Back Chapter, lumbar supports states, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." Under treatment ODG

further states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." In this case, the patient does not present with fracture, documented instability, or spondylolisthesis to warrant lumbar bracing. For non-specific low back pain, there is very low quality evidence. The treater has asked for lumbar support for "support" and ODG does not support bracing for prevention. Recommendation is for denial.

**Left Shoulder intra-articular injection, injection: aspiration, acromioclavicular joint subacromial bursa, manipulation of shoulder with lysis of adhesions under anesthesia:**  
Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 235 and 236, 213, Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) Shoulder chapter, Manipulation under anesthesia (MUA).

**Decision rationale:** This patient presents with left shoulder and low back pain. This is a request for "left shoulder intraarticular injection: injection, aspiration, acromioclavicular joint subacromial bursa, manipulation of shoulder with lysis of adhesions under anesthesia." The Utilization review denied the request stating that documentation indicates "the claimant is not interested in any type of aggressive treatment or injection." ACOEM guidelines page 235 and 236 states "corticosteroid injections have been shown to be effective, at least in the short term; however, the evidence on long-term effects is mixed, some studies show high recurrence rate among injection groups." For shoulder, ACOEM p213 allows for 2-3 injections as part of a rehabilitation program. ODG guidelines recommend up to 3 injections. There is no indication that the patient has trialed injections for the shoulder. Given the patient's continued pain, decreased ROM, crepitating and positive findings, a trial of left shoulder intraarticular injection is within guidelines. Recommendation is for approval. In regards to the requested Manipulation under Anesthesia the ODG guidelines under its Shoulder chapter states that MUA is under study and may be an option for adhesive capsulitis. "MUA may be recommended as an option in primary frozen shoulder to restore early range of movement and to improve early function in this often protracted and frustrating condition." In this case, the patient has severely restricted motion and positive Neer's, Hawkins', Anterior apprehension and Jobe's empty can tests. The request appears medically reasonable with some support from ODG guidelines quoted above. Recommendation is for authorization.

**X-ray:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) chapter on Radiography (X-rays shoulder)

**Decision rationale:** The patient presents with pain in left shoulder and lower back, rated at 6-9/10, that radiates to bilateral lower extremities, as per progress report dated 10/02/14. The request is for X-RAY. As per ODG Guidelines, Shoulder (Acute & Chronic) chapter on Radiography (X-rays shoulder), states that Plain radiographs should be routinely ordered for patients with chronic shoulder pain, including anteroposterior, scapular Y, and axillary views." Indications for x-rays include: (a) Acute shoulder trauma, rule out fracture or dislocation (b) Acute shoulder trauma, questionable bursitis, blood calcium (Ca+)/approximately 3 months duration, first study. In this case, the request is for x-ray. Although the request does not mention the body part for which the procedure is requested, the Utilization Review Denial Letter states that the procedure is for the left shoulder. The patient suffers from chronic pain in the shoulder rated at 6-9/10. Physical examination of the left shoulder reveals tenderness in the entire shoulder joint along with severely diminished range of motion. The symptoms have been persistent since the date of injury. The patient is only relying on conservative care and is not interested in invasive procedures. The patient received an X-ray for the left shoulder which revealed mild AC joint arthritis, as per progress report dated 05/13/14. However, the report does not mention the exact date of the procedure. Review of the available documents did not reveal the original X-ray report or additional findings. The patient has also received a MRI for the Left Shoulder on 09/19/14. The treater does not explain why another x-ray of the left shoulder is needed and how it will impact treatment. Recommendation is for denial.