MAXIMUS Federal Services

Case Number:	CM15-0002739		
Date Assigned:	01/14/2015	Date of Injury:	01/30/2012
Decision Date:	04/03/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	01/06/2015

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: Hawaii, California, Iowa
Certification(s)/Specialty: Preventive Medicine, Occupational 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 44 year old male, who sustained an industrial injury on January 30, 2012. The diagnoses have included status post C5-C6 anterior cervical discectomy and fusion with cage and instrumentation on November 7, 2012, C5-C6 stenosis, C5-C6 disc degeneration, very mild subacromial bursitis of the left shoulder, chronic left C7 radiculopathy confirmed by electromyography (EMG) dated August 26, 2014, left shoulder impingement with type II acromion, C6-C7 stenosis, and right L4 radiculopathy. Treatment to date has included cervical spine fusion in 2012, trigger point injections, epidural steroid injection (ESI), and medications. Currently, the injured worker complains of severe constant neck pain with numbness and pain radiating into the left shoulder and down the arm into the hand, with right sided low back pain radiating into the right hip and down the right anterior and posterior thigh with pain and numbness. The Primary Treating Physician's report dated November 21, 2014, noted the cervical spine with evidence of tenderness to palpation over the left trapezius, left cervical paraspinal musculature, left base of skull and neck, and left interscapular space, with decreased sensation over the left C5, C6, C7, C8, and T1 dermatome distribution. Palpable tenderness was noted over the posterior shoulder musculature. The injured worker received a left shoulder injection, and a right lumbar trigger point injection. On December 12, 2014, Utilization Review non-certified Percocet 10/325mg #180, Soma 350mg #90, physical therapy to the lumbar spine x6, MRI of the lumbar spine, and left shoulder arthroscopy with acromioplasty. The Percocet was not medically necessary, however was modified to #162 to allow for potential weaning at 10% over a four week period. The Soma was not medically necessary, however was modified to

#81, to allow for potential weaning at 10% over a four week period. The guideline criteria for the left shoulder arthroscopy with acromioplasty was not met, therefore the request was not medically necessary or reasonable. The guideline criteria for the MRI of the lumbar spine had not been met, therefore the request was no medically necessary or reasonable. The request for physical therapy was modified to #2 to allow for functional improvement and/or decrease in pain, re-education in a prescribed self-administered program and assessment of compliance. The MTUS Chronic Pain Medical Treatment Guidelines and the MTUS American College of Occupational and Environmental Medicine Guidelines were cited. On January 6, 2015, the injured worker submitted an application for IMR for review of Percocet 10/325mg #180, Soma 350mg #90, physical therapy to the lumbar spine x6, MRI of the lumbar spine, and left shoulder arthroscopy with acromioplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg, #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids.

Decision rationale: Percocet (oxycodone with acetaminophen) is a short-acting opioid. Chronic pain guidelines and ODG do not recommend opioid "except for short use for severe cases, not to exceed 2 weeks" and "Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficulty weaning." Medical documents indicate that the patient has been on Percocet for several months, in excess of the recommended 2 week limit. Additionally, indications for when opioids should be discontinued include "If there is no overall improvement in function, unless there are extenuating circumstances." MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the request for Percocet 10/325mg, #180 is not medically necessary as written.

Soma 350mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) and Muscle relaxants (for pain) Page(s): 29, 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Soma (Carisoprodol).

Decision rationale: MTUS states regarding Crisoprodol, "Not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. 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. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs." ODG States that Soma is "Not recommended. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy (AHFS, 2008). This medication is not indicated for long-term use." The medical records do not indicate to justify long term soma usage. No ongoing improvement was noted due to medication. The prescription was modified by the original reviewer to allow for weaning, which is appropriate.

Physical therapy to the lumbar spine x6: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Based on the medical records provided, there does not appear to be evidence of lumbar physical therapy. The initial request for 6 sessions is consistent with a 'trial' and appropriate per MTUS guidelines. As such, the request for Physical therapy to the lumbar spine x 6 is medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging).

Decision rationale: MTUS and ACOEM recommend MRI, in general, for low back pain when "cuada equine, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative, MRI test of choice for patients with prior back surgery." ACOEM additionally recommends against MRI for low back pain "before 1 month in absence of red flags." ODG states, "Imaging is indicated only if they have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms." The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags, significant worsening in symptoms or other findings suggestive of the pathologies outlined in the above guidelines. As such, the request for MRI lumbar spine is not medically necessary.

Left shoulder arthroscopy with acromioplasty: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Surgery for impingement syndrome.

Decision rationale: ODG recommends "acromioplasty for acromial impingement syndrome as indicated below, after at least 3-6 months of conservative care. Not recommended in conjunction with full-thickness rotator cuff repair."ODG further details:Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.) 1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive

evidence of impingement. Medical records do indicate some subjective and objective clinical findings consistent with impingement. The medical records, however, do not indicate the 3-6 months of failed conservative therapy required per guidelines. As such, the request for Left shoulder arthroscopy with acromioplasty is not medically necessary at this time.