

Case Number:	CM15-0108975		
Date Assigned:	06/15/2015	Date of Injury:	02/28/2015
Decision Date:	09/23/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	06/05/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 2/28/2015. He reported pain while moving metal from a pile of trash. The injured worker was diagnosed as having back pain, thoracic pain and left shoulder pain. There is no record of a recent diagnostic study. Treatment to date has included ice, 12 visits of physical therapy and medication management. In a progress note dated 4/28/2015, the injured worker complains of left shoulder and upper back pain. Physical examination showed left scapular tenderness with muscle spasm. The treating physician is requesting Cyclobenzaprine Hcl 10 mg #30 (3/21/2015), Physical therapy re-evaluation, upper back, per 4/23/2015 order, Hot or cold packs, 3 times weekly, upper back, per 04/28/2015 order, electrical stimulation, 3 times weekly, upper back, per 4/28/15 order # 6, therapeutic exercises 3 x weekly for 2 weeks for the upper back-4/28/2015 and myofascial release, 3 times weekly, upper back, per 4/28/15 order # 6.00.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine Hcl 10mg, per 3/321/15 order Qty: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: Based on the 4/23/15 progress report provided by the treating physician, this patient presents with acute shoulder blade and upper back pain that radiates around left side of rib cage (dermatomal without rash). Also, the patient's back locks up and has night pain per 4/23/15 report. The treater has asked for Cyclobenzaprine Hcl 10mg, per 3/31/15 order Qty: 30.00 per 3/31/15 report. The request for authorization was not included in provided reports. The patient is currently taking Nabumetone, Hydrocodone, Cyclobenzaprine as of 4/23/15. The patient describes his shoulder pain as improved, but his back pain is unchanged per 4/23/15 report. The patient is on modified work with no use of left hand above chest level per 4/10/15 report. The patient's previous treatments have included physical therapy, medications, and icing per review of reports. MTUS Chronic Pain Guidelines, Muscle relaxants (for pain) section, page 63-66 states "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are Carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects. The patient has been utilizing Cyclobenzaprine since 3/17/15 for his muscle spasms. Although the patient states that his medication does provide significant relief, recommendation for further use cannot be supported as MTUS Guidelines supports the use of these types of muscle relaxants for short course of therapy, not longer than 2 to 3 weeks. This request is not medically necessary.

Physical therapy re-evaluation, upper back, per 4/28/215 order Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Physical medicine guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: Based on the 4/23/15 progress report provided by the treating physician, this patient presents with acute shoulder blade and upper back pain that radiates around left side of rib cage (dermatomal without rash). Also, the patient's back locks up and has night pain per 4/23/15 report. The treater has asked for Physical therapy re-evaluation, upper back, per 4/28/215 order Qty: 1.00 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient is currently taking Nabumetone, Hydrocodone, Cyclobenzaprine as of 4/23/15. The patient describes his shoulder pain as improved, but his back pain is unchanged per 4/23/15 report. The patient is on modified work with no use of left hand above chest level per 4/10/15 report. The

patient's previous treatments have included physical therapy, medications, and icing per review of reports. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM guidelines, chapter 7, page 127 state that the 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. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. MTUS Guidelines pages 98 to 99 state that for patients with "myalgia and myositis, 9 to 10 sessions over 8 weeks are allowed, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits over 4 weeks are allowed." In this case, the patient has had physical therapy in the past. Per report dated 3/31/15, the patient recently completed 6 physical therapy sessions which were "minimally effective." As per progress report dated 4/23/15, the patient completed 6 additional physical therapy sessions which were also "minimally effective." The treater is now requesting for a re-evaluation for further therapy but does not explain its necessity, considering prior 12 sessions were only minimally effective. The treater does not seem to address any need for repeat evaluation, hence the request is not medically necessary.

Hot or cold packs, 3 times weekly, upper back, per 04/28/2015 order Qty: 6.00: 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) Pain Chapter under, Cold/Heat Packs section.

Decision rationale: Based on the 4/23/15 progress report provided by the treating physician, this patient presents with acute shoulder blade and upper back pain that radiates around left side of rib cage (dermatomal without rash). Also, the patient's back locks up and has night pain per 4/23/15 report. The treater has asked for Hot or cold packs, 3 times weekly, upper back, per 04/28/2015 order Qty: 6.00 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient is currently taking Nabumetone, Hydrocodone, Cyclobenzaprine as of 4/23/15. The patient describes his shoulder pain as improved, but his back pain is unchanged per 4/23/15 report. The patient is on modified work with no use of left hand above chest level per 4/10/15 report. The patient's previous treatments have included physical therapy, medications, and icing per review of reports. ODG Guidelines Pain Chapter under Low Back-Lumbar & Thoracic Chapter, Cold/Heat Packs section states: Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007).The

patient has full range of motion without pain of the T-spine per 4/23/15 report. However, physical exam shows an inferior border of the scapula on his T-spine with mild-moderate soft tissue tenderness to palpation, spasm and point tenderness with pain radiating to right ribs per 4/23/15 report. The treater does not provide a reason for the request. ODG guidelines state that there is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. As this request is for both hot and cold packs, the request is not medically necessary due to lack of guideline support.

Electrical stimulation, 3 times weekly, upper back, per 4/28/15 order Qty: 6.00: 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 Physical Medicine Page(s): 98, 99.

Decision rationale: Based on the 4/23/15 progress report provided by the treating physician, this patient presents with acute shoulder blade and upper back pain that radiates around left side of rib cage (dermatomal without rash). Also, the patient's back locks up and has night pain per 4/23/15 report. The treater has asked for Electrical stimulation, 3 times weekly, upper back, per 4/28/15 order Qty: 6.00 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient is currently taking Nabumetone, Hydrocodone, Cyclobenzaprine as of 4/23/15. The patient describes his shoulder pain as improved, but his back pain is unchanged per 4/23/15 report. The patient is on modified work with no use of left hand above chest level per 4/10/15 report. The patient's previous treatments have included physical therapy, medications, and icing per review of reports. MTUS Physical Medicine Section, pages 98, 99 has the following: "Recommended as indicated below. Allow for fading of treatment frequency -from up to 3 visits per week to 1 or less-, plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." In this case, the patient presents with acute pain of the back and shoulder. The utilization review letter dated 5/4/15 denies the request and cites MTUS Physical Medicine Guidelines for myalgia and myositis (8-10 visits over 4 weeks). The treater does not discuss this request in the reports provided. It appears the request is for physical therapy sessions that include electrical stimulation. The requested weekly electrical stimulation sessions are not indicated, as the patient has already had 12 sessions of physical therapy. Another 18 sessions would exceed MTUS guidelines for this type of condition. The request is not medically necessary.

Therapeutic exercises, 3 times weekly, upper back, per 4/28/2015 Qty: 6.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine guidelines Page(s): 99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter under Exercise.

Decision rationale: Based on the 4/23/15 progress report provided by the treating physician, this patient presents with acute shoulder blade and upper back pain that radiates around left side of rib cage (dermatomal without rash). Also, the patient's back locks up and has night pain per 4/23/15 report. The treater has asked for Therapeutic exercises, 3 times weekly, upper back, per 4/28/2015 Qty: 6.00 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient is currently taking Nabumetone, Hydrocodone, Cyclobenzaprine as of 4/23/15. The patient describes his shoulder pain as improved, but his back pain is unchanged per 4/23/15 report. The patient is on modified work with no use of left hand above chest level per 4/10/15 report. The patient's previous treatments have included physical therapy, medications, and icing per review of reports. ODG-TWC, Pain (Chronic) Chapter under Exercise states: Recommended. There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime. (State, 2002) Treater does not discuss the request. In this case, ODG supports the treatment of therapeutic exercises. However, treater does not explain how and what is to be done. In addition, there is no explanation as to why the therapeutic exercises cannot be performed at home and why a therapist or professional intervention is needed. Therefore, the request is not medically necessary.

Myofascial release, 3 times weekly, upper back, per 4/28/15 order Qty: 6.00: 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 massage therapy Page(s): 60.

Decision rationale: Based on the 4/23/15 progress report provided by the treating physician, this patient presents with acute shoulder blade and upper back pain that radiates around left side of rib cage (dermatomal without rash). In addition, the patient's back locks up and has night pain per 4/23/15 report. The treater has asked for Myofascial release, 3 times weekly, upper back, per 4/28/15 order Qty: 6.00 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient is currently taking Nabumetone, Hydrocodone, Cyclobenzaprine as of 4/23/15. The patient describes his shoulder pain as improved, but his back pain is unchanged per 4/23/15 report. The patient is on modified work with no use of left hand above chest level per 4/10/15 report. The patient's previous treatments have included physical therapy, medications, and icing per review of reports. MTUS Guidelines, Part 2 (Pain Interventions and Treatments) under massage therapy on pg. 60 states that it is recommended as an option and as an adjunct with other recommended

treatments such as exercise and should be limited to 4 to 6 visits. Massage is a passive intervention and treatment, dependence should be avoided. In this case, the patient suffers from acute shoulder and back pain. The treater does not discuss this request in the reports provided. Review of the reports do not show any evidence of prior massage treatments. MTUS recommends 4 to 6 sessions of massage therapy as an adjust with other treatments. However, the current request for 18 sessions of myofascial release exceed what MTUS recommends. The request is not medically necessary.