

Case Number:	CM15-0018227		
Date Assigned:	03/11/2015	Date of Injury:	02/10/1999
Decision Date:	04/23/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	01/30/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 68 year old female, who sustained an industrial injury on 2/10/1999. The diagnoses have included chronic pain. Treatment to date has included surgical and conservative measures. On 3/17/2014, the injured worker was seen for re-examination. Magnetic resonance imaging of the left shoulder (10/31/2013) was referenced as showing left supraspinatus and infraspinatus tendinosis, mild left acromioclavicular osteoarthritis, a small amount of subacromial/subdeltoid bursal fluid, and evidence of prior left shoulder surgery. Magnetic resonance imaging of the right shoulder (10/13/2013) was referenced as showing supraspinatus and infraspinatus tendinosis, accompanied by mild atrophy of the corresponding muscles, small bursal fluid within the subacromial/subdeltoid space, and prior right shoulder surgery. Prior comprehensive neurocognitive assessment and evaluation (8/23/2013) was documented as showing a diagnosis of major depression, recurrent, severe without psychotic features. The recommended acupuncture treatments and aquatherapy were not yet started. She reported pain in both shoulders. She had craniocervical and occipital tenderness. Mental status exam was within normal limits and memory testing was "difficult". A weak bilateral hand grip was noted, right greater than left. Mild weak right dorsiflexion was noted. Decreased sensation was noted at the bilateral hypothenar regions, outer thighs, and foot plantar aspects. Romberg test was positive. Severe tenderness and spasm was noted to the cervical and interscapular regions, shoulders, and wrists. Tinel's sign was positive at both wrists. Straight leg raise testing was positive on the left at 40 degrees and 60 degrees on the right. Current medications were not listed. On 1/16/2015, Utilization Review non-certified a request for Flurbiprofen cream 20%, citing MTUS Chronic

Pain Medical Treatment Guidelines, non-certified a request for Tramadol ointment 20%, citing MTUS Chronic Pain Medical Treatment Guidelines, non-certified a request for Aquatherapy (3x4-12 sessions), citing MTUS Chronic Pain Medical Treatment Guidelines, non-certified a request for Cyclobenzaprine 7.5mg #60, citing MTUS Chronic Pain Medical Treatment Guidelines, non-certified a request for repeat cervical magnetic resonance imaging, citing Official Disability Guidelines, non-certified a request for Cyclobenzaprine 10%/Gabapentin 10% compound cream, citing MTUS Chronic Pain Medical Treatment Guidelines, non-certified a request for Pantoprazole 20mg #30, citing MTUS Chronic Pain Medical Treatment Guidelines, non-certified a request for magnetic resonance imaging of the right shoulder, citing Official Disability Guidelines, and non-certified a request for magnetic resonance imaging of the left shoulder, citing Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20% cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, there is no documentation provided necessitating Flurbiprofen cream. There is no documentation of intolerance to other previous oral medications. Flurbiprofen, used as a topical NSAID, has been shown to be superior to placebo during the first two weeks of treatment for osteoarthritis but either not afterward, or with diminishing effect over another two-week period. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Tramadol 20% ointment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound requested is Tramadol 20% ointment. Tramadol is not FDA approved as a topical analgesic application. There is no documentation of intolerance to other previous oral medications. Medical necessity for the requested topical analgesic has not been established. The requested treatment is not medically necessary.

Twelve sessions of aquatic therapy, three times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

Decision rationale: According to CA MTUS Guidelines (2009), aquatic therapy is recommended as an optional form of exercise therapy, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight-bearing is desirable (for example, extreme obesity). Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. In this case, there is limited documentation of significant functional improvement from previous aqua-therapy. In addition, the documentation did not indicate the reason aqua-therapy is being requested as an alternative to land-based physical therapy when it is documented the patient is undergoing physiotherapy. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: Flexeril (Cyclobenzaprine) is a skeletal muscle relaxant and a central nervous system (CNS) depressant with similar effects to tricyclic antidepressants. It has a central mechanism of action, but it is not effective in treating spasticity from cerebral palsy or spinal cord disease. According to CA MTUS Guidelines, muscle relaxants are not considered

any more effective than nonsteroidal anti-inflammatory medications alone. Flexeril is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four (4) days of treatment. This medication is not recommended to be used for longer than 2-3 weeks. In this case, there are no muscle spasms documented on physical exam. There is no documentation of objective functional improvement from any previous use of this medication. Based on the currently available information, the medical necessity for Flexeril, has not been established. The requested medication is not medically necessary.

Repeat cervical MRI: 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), Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI of the cervical spine.

Decision rationale: According to CA MTUS/ACOEM guidelines, a cervical MRI is indicated if unequivocal findings identify specific nerve compromise on the neurologic examination, in patients who do not respond to conservative treatment, and who would consider surgical intervention. Cervical MRI is the mainstay in the evaluation of myelopathy. Per the ODG, MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the documentation indicates that the patient had a previous cervical MRI on 10/28/13. There are no new neurologic findings on physical exam to warrant another MRI study. Medical necessity for the requested service is not established. The requested service is not medically necessary.

Compound cream Cyclobenzaprine 10% and Gabapentin 10%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, there is no documentation of intolerance to other previous oral medications. Gabapentin and Cyclobenzaprine not recommended as a topical

agents per CA MTUS Guidelines. Medical necessity for the requested topical cream has not been established. The requested topical cream is not medically necessary.

Pantoprazole 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation www.drugs.com/pro/pantoprazole.html.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Proton Pump inhibitors.

Decision rationale: According to the California MTUS (2009), Pantoprazole (Protonix), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. In this case, there is no documentation indicating that the patient has had any improvement in her GI symptoms on this medication. Based on the available information provided for review, medical necessity has not been established. The requested medication is not medically necessary.

MRI of the right 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), Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI of the shoulder.

Decision rationale: The ODG recommends an MRI of the shoulder for the evaluation of acute shoulder trauma, suspected rotator cuff tear/impingement, over age 40; with normal plain radiographs, for the evaluation of subacute shoulder pain, suspected instability, or labral tear. A repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the patient has undergone multiple surgeries on the right shoulder and has chronic shoulder pain. She has been declared 100% permanently totally disabled. There is no specific indication for a right shoulder MRI. Medical necessity for the requested MRI study is not established. The requested study is not medically necessary.

MRI of the 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), Shoulder.

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

Decision rationale: The ODG recommends an MRI of the shoulder for the evaluation of acute shoulder trauma, suspected rotator cuff tear/impingement, over age 40; with normal plain radiographs, for the evaluation of subacute shoulder pain, suspected instability, or labral tear. A repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the patient has undergone multiple surgeries on the right shoulder and has chronic shoulder pain. She has been declared 100% permanently totally disabled. There is no specific indication for a left shoulder MRI. Medical necessity for the requested MRI study is not established. The requested study is not medically necessary.