

Case Number:	CM15-0018840		
Date Assigned:	02/09/2015	Date of Injury:	07/22/2014
Decision Date:	04/03/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/02/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 26-year-old female who reported an injury on 07/22/2014. The mechanism of injury was not provided. An official MRI on 11/25/2014 read by [REDACTED] noted no acute findings identified. Intact rotator cuff tendons. Trace fluid in the subacromial subdeltoid bursa may indicate subacute tendons strain, mild. Trace physiologic fluid. An official MRI of the lumbar spine performed on 11/25/2014 read by [REDACTED] which was noted to reveal at the L4-5, there is disc desiccation, mild disc height loss, and 2 mm of annular disc bulging. Mild facet arthritis. No significant central canal narrowing or foraminal narrowing. Minor facet arthritis bilaterally with trace facet effusions. Normal conus medullaris at the T12 level. The clinical note dated 01/08/2015 noted radiating low back pain, bilateral shoulder pain, and numbness of the bilateral feet. Examination revealed tenderness to palpation over the lumbar paraspinal muscles with spasms, decreased range of motion of the lumbar spine, and decreased range of motion of the bilateral shoulders. The medical reports identify that the injured worker is benefitting from chiropractic treatment and requests for naproxen, omeprazole, Flexeril, and Neurontin were made. Diagnoses included myofascial pain syndrome, lumbar sprain/strain, bilateral rotator cuff syndrome, and lumbosacral radiculopathy. Treatments included chiropractic treatments and medications. The request is for right shoulder Kenalog injection, naproxen, omeprazole, Flexeril, Neurontin, Mentherm, manipulation, 8 sessions of chiro, and ESI lumbar L4, L5, and S1. The Request for Authorization was dated 01/08/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder Kenalog injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/kenalog-10.html>.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: PDR.

Decision rationale: The request for right shoulder Kenalog injection is not supported. The injured worker has a history of back and shoulder pain. The CA MTUS/ACEOM state pain relief is often a patient's first concern. Nonprescription analgesics may provide sufficient pain relief for most patients with acute and subacute symptoms. If treatment response is inadequate (i.e., if symptoms and activity limitations continue), prescribed pharmaceuticals or physical methods can be added. The PDR states that intra-articular or soft tissue administration of Kenalog ten injections is indicated as injection therapy for short term administration to a patient over an acute episode or exacerbation. Also, documentation on the MRI of the right shoulder identify mild tendinosis of the supraspinatus tendon and traces overlying fluid in the subacromial subdeltoid bursa, which is nonspecific finding and may be occasionally seen with mild tendon sprain, there is insignificant documentation of acute arthritis, bursitis, tenosynovitis, epicondylitis, rheumatoid arthritis, stenosis, or osteoarthritis. The request is not supported. As such, the request for right shoulder Kenalog injection is not medically necessary.

Naproxen: 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: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The request for naproxen is not supported. The injured worker has a history of low back and shoulder pain. The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDS are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDS for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The guidelines support the use of NSAIDs in management of pain. There is lack of documentation of the quantity and strength within the request. The request is not supported. As such, the request for naproxen is not medically necessary.

Omeprazole: 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), Pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68, 69.

Decision rationale: The request for omeprazole is not supported. The injured worker has a history of low back and shoulder pain. The California Medical Treatment Utilization Schedule Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. Therefore, the injured worker does not currently meet criteria for the requested medication. There is also no strength, frequency or quantity listed in the request. Although the injured worker has an ongoing history of NSAID therapy, the request lacks frequency and dosage. The request is not supported. As such, the request is not medically necessary.

Flexeril: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter.

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

Decision rationale: The request for Flexeril is not supported. The injured worker has a history of low back and shoulder pain. The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time and there is a lack of documentation of objective improvement. There is documentation of the injured worker having muscle spasms. There is lack of documentation of the injured worker having acute spasms and the intent to treat them over a short period of time. There is lack of documentation of the frequency and dosage provided within the request. The request is not supported. As such, the request is not medically necessary.

Neurontin: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16, 17.

Decision rationale: The request for Neurontin is not supported. The injured worker has a history of low back and shoulder pain. The California MTUS guidelines recommend anti-epilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. There is documentation of neuropathic pain; however, there is a lack of documentation of the quantity and dosage within the request. The request is not supported. As such, the request is non-certified.

Menthoderm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Drugs.com.

Decision rationale: The request for Mentoderm is not supported. The injured worker has a history of low back and shoulder pain. The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is documentation of neuropathic pain. There is lack of documentation of a trial of antidepressants or anticonvulsants that have been failed. The request does not document the quantity or area of use. The request is not supported. As such, the request is not medically necessary.

Manipulation, 8 sessions of Chiro: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 57-58.

Decision rationale: The request for manipulation, 8 sessions of chiro is not supported. The injured worker has a history of low back and shoulder pain. The CA MTUS guidelines state manual therapy & manipulation is recommended for chronic pain if caused by musculoskeletal conditions. After a trial of 6 visits over 2 weeks with evidence of objective functional improvement, a total of 18 visits may be warranted. There needs to be documentation of functional improvement. Elective/maintenance care is not medically necessary. Flare-ups and reoccurrences need to be re-evaluated. There is documentation that the injured worker is making progress with chiropractic care. There is lack of documentation to identify why an independent home exercise program would not be sufficient to address any remaining functional deficits to support the medical necessity for additional chiropractic care. There is lack of documentation of the number of previous sessions received. If the number of treatments has already exceeded

chiropractic treatment, exceptional factors would need to be given to warrant additional chiropractic care. There is lack of documentation from the previous chiropractic care of objective improvement. There is lack of documentation to the frequency within the request. The request is not supported. As such, the request for manipulation, 8 sessions of chiro is not medically necessary.

ESI Lumbar L4, L5, S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Criteria for the use of epidural steroid injections, and on the Non-MTUS AMA Guides, 5th Edition, page 382-383.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: The request for ESI lumbar L4, L5, S1 is not supported. The injured worker has a history of low back and shoulder pain. The CA MTUS guidelines recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Also, there is documentation of radiating low back pain and bilateral feet numbness and tenderness to palpation of the lumbar paraspinal muscles with spasms and decreased range of motion of the lumbar spine. There is no specific nerve root distribution documented or pain, numbness, or tingling and sensory changes, motor changes, or reflex changes noted in the radicular findings in the requested nerve root distribution. There is lack of documentation of MRI findings for each of the requested levels. There is lack of documentation of failed conservative treatment. The request is not supported. As such, the request for ESI lumbar L4, L5, S1 is not medically necessary.