MAXIMUS Federal Services

Case Number:	CM15-0019454		
Date Assigned:	02/09/2015	Date of Injury:	09/10/2012
Decision Date:	04/07/2015	UR Denial Date:	12/30/2014
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: 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 44 year old female who sustained a work related injury on September 10, 2012, after a fall backward from a desk and injuring her buttocks, back, elbows and head. Diagnoses included cervical spine sprain and elbow contusions, In April, 2013; she was diagnosed with a shoulder impingement and rotator cuff tendinitis. Treatment included steroid injections, physical therapy and a diagnostic arthroscope of the shoulder. Currently, in December, 2014, the injured worker reports worsening pain in the left shoulder due to an impingement syndrome. On December 30, 2014, a request for a service of physical therapy twice a week for 6 weeks; a left shoulder nerve block, ultrasound guided needle placement; and a prescription of Prilosec 20mg #60 was non-certified by Utilization Review, noting the California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines. A request for a prescription of Voltaren 100mg #60 was modified to a prescription of Voltaren 50mg #60, by Utilization Review, noting the California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy x 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy/Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient has had 52 PT visits since her injury in 09/2012. There is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the additional 12 PT (2x6) sessions requested, and the additional visits exceed the MTUS and ODG guidelines. Medical necessity for the additional PT visits requested, have not been established. The requested services are not medically necessary.

Retrospective: (L) Shoulder Nerve Block & (L) Shoulder Subacromial space kenalog 6 units, 3 cc 0.5% Marcaine under ultrasound guided needle placement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://odg-twc.com/odgtwc/shoulder.htm) and Nerve blocks, Rotator cuff, and Imaging guidance for shoulder injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter: Nerve Blocks, Impingement, Steroid injections.

Decision rationale: According to the ODG, nerve blocks involving the shoulder include a suprascapular block which is used for the treatment of pain from degenerative disease, arthritis, impingement, and postoperative pain due to shoulder arthroscopy. It can improve pain, disability, and range of motion. Guidelines support this nerve block, with ultrasound (u/s) guidance, for the treatment of shoulder pain/shoulder impingement, but the pain relief is only short-term. In this case, the patient has left shoulder pain/impingement with left rotator cuff tendinosis. The ODG recommends subacromial steroid injections for the treatment of rotator cuff disease. Corticosteroid injections may be superior to physical therapy interventions for short-term results, with a maximum of three recommended. Subacromial injections of corticosteroids are effective for improvement for rotator cuff tendonitis up to a 9-month period. They are also probably more effective than NSAID medication. [The subacromial steroid injection was already approved by UR.] However, there is no indication for both injections (nerve block and steroid injection) to be

done at the same time Medical necessity for the requested retrospective left shoulder nerve block, under u/s guidance has not been established. The requested procedure is not medically necessary.

Retrospective: Voltaren 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs, Voltaren.

Decision rationale: Voltaren is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute pain and acute exacerbations of chronic pain. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient had prior use of on NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective functional improvement. Medical necessity of the requested medication has not been established. The retrospective Voltaren is not medically necessary.

Retrospective: Prilosec 20mg # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Prilosec.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPI's Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPI's.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), 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 this patient had any GI symptoms or risk factors. In addition, the request for Voltaren was found to be not medically necessary, which would mean that the Prilosec would not appear to be medically necessary for this patient. Medical necessity for Prilosec has not been established. The requested retrospective medication is not medically necessary.