

Case Number:	CM15-0162070		
Date Assigned:	08/28/2015	Date of Injury:	01/20/2015
Decision Date:	09/30/2015	UR Denial Date:	07/20/2015
Priority:	Standard	Application Received:	08/18/2015

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 58-year-old male, with a reported date of injury of 01-20-2015. The mechanism of injury was not indicated in the medical records provided for review. The injured worker's symptoms at the time of the injury were not indicated. The diagnoses include status post remote right shoulder rotator cuff repair; retest of rotator cuff, right shoulder; facet osteoarthropathy L4-5 and L5-S1; and central canal stenosis/neural encroachment lower lumbar spine. Treatments and evaluation to date have included oral medications and physical therapy. The diagnostic studies to date have not been included in the medical records. The medical report dated 06-15-2015 indicates that the injured worker had right shoulder surgery in 2012 with initial improvement; however, the condition was now worsening. The injured worker rated his right shoulder pain 8 out of 10, and his low back pain with right lower extremity symptoms 8 out of 10. It was noted that the medication at the current dosing helps with the maintenance of his activities of daily living. Without medication, the injured worker's activities of daily living were in jeopardy; and there was the frequent inability to adhere to the recommended exercise regimen due to pain. The objective findings include tenderness of the lumbar spine; lumbar flexion at 40 degrees; lumbar extension at 35 degrees; lumbar left and right lateral tilt at 35 degrees; lumbar left and right rotation at 30 degrees; positive right straight leg raise test; diminished sensation at the right L5 and S1 dermatomal distributions; tenderness of the right shoulder; right shoulder abduction at 100 degrees; right shoulder flexion at 110 degrees; positive impingement signs; and atrophy of the right deltoid musculature. It was noted that the MRI of the right shoulder on 05-19-2015 showed post surgical changes and repair of rotator cuff; and

an MRI of the lumbar spine on 05-19-2015 showed facet osteoarthropathy of the lower lumbar spine and canal stenosis with neural encroachment. The injured worker denied interventional treatment of the lumbar spine. The treatment plan included additional physical therapy for the lumbar spine three times a week for four weeks; Tramadol, two tablets daily; Naproxen, one tablet three times a day; Pantoprazole, one tablet three times a day; and Cyclobenzaprine, one tablet three times a day as needed for intractable spasm. The injured worker is temporarily partially disabled with no driving of a truck greater than four hours per workday, and no lifting. The treating physician requested additional physical therapy three times a week for four weeks; Tramadol ER 150mg #60; Naproxen Sodium 550mg #90; Pantoprazole 20mg #90; and Cyclobenzaprine 7.5mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical Therapy 3 times per week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: The CA MTUS Chronic Pain Guidelines recommend passive and active therapy. Passive therapy can provide short-term relief during the early phases of pain treatment; control symptoms of pain, inflammation, and swelling; and help improve the rate of healing soft tissue injuries. Active therapy is beneficial for restoring flexibility, strength, endurance, function, range of motion, and can relieve discomfort. The guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The treating physician requested 12 additional physical therapy sessions for the lumbar spine. It was noted that emphasis should be placed on active therapy; and there was concern in regards to the myofascial component of the lumbar spine and lumboparaspinal musculature. For myalgia and myositis, 9-10 visits over 8 weeks are recommended. The CA MTUS ACOEM Guidelines recommend 1-2 visits for education, counseling, and evaluation of home exercise for range of motion and strengthening. Specific low back exercises for range of motion and strengthening are recommended. The physical therapy reports were not included in the medical records provided for review. The request exceeds guideline recommendation. Therefore, the request for twelve additional physical therapy sessions for the lumbar spine is not medically necessary.

Tramadol ER 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity of the requested Tramadol ER has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Naproxen Sodium 550mg #90: 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 rationale: Naproxen (Aleve or Naprosyn) 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. The ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic pain, and short-term pain relief in chronic LBP. 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 NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective benefit from use of this medication. Medical necessity of the requested medication has not been established. The request for Naproxen is not medically necessary.

Pantoprazole 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: According to the CA MTUS, proton pump inhibitors, such as Pantoprazole (Protonix), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation indicating the patient has any GI symptoms

or GI risk factors. In this case, Naproxen was not found to be medically necessary. Medical necessity for Pantoprazole has not been established. The requested medication is not medically necessary.

Cyclobenzaprine 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

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

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system (CNS) depressant. It is closely related to the tricyclic antidepressants. It is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. In this case, the available records show that the patient has not shown a documented benefit or any functional improvement from prior Cyclobenzaprine use. In addition, there is no clinical indication presented for the chronic or indefinite use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested medication is not medically necessary.