

Case Number:	CM15-0181911		
Date Assigned:	09/23/2015	Date of Injury:	08/14/2006
Decision Date:	11/24/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/15/2015

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, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic Surgery

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 48 year old male, who sustained an industrial injury on 08-14-2006. He has reported injury to the left shoulder. The injured worker has been treated for chronic left shoulder pain; left shoulder impingement; left shoulder internal derangement; left shoulder type II acromion; and bilateral shoulder impingement with rotator cuff strain and bicipital tendinitis. Treatment to date has included medications, diagnostics, activity modification, injections, and physical therapy. Medications have included Norco, Flector Patch, and Ibuprofen. A progress report from the treating physician, dated 08-26-2015, documented an evaluation with the injured worker. The injured worker reported constant left shoulder pain; the pain is rated as 6-8 out of 10 in intensity; he reports weakness of the arm; the pain is worse with using the arm; the pain is better with ice, heat, and medications; he has been receiving Norco and Ibuprofen for pain; and he has failed conservative treatment including 11 prior injections, and more than 24 physical therapy sessions for the left shoulder. Objective findings included positive impingement, Hawkins, and Speed's test bilaterally; positive cross-arm test bilaterally; tenderness along the acromioclavicular joint, rotator cuff, biceps tendon, and posterior capsule bilaterally; range of motion with discomfort in both shoulder; and abduction strength is 5- out of 5 bilaterally. The provider noted that the MR (Magnetic Resonance) Arthrogram of the left shoulder, dated 07-27-2015, "demonstrates type II acromion with the lateral acromion downsloping, osteophytic changes of the AC joint, small full-thickness tear of the anterior supraspinatus musculotendinous junction with supraspinatus tendinopathy noted, and fibrous scarring noted in subdeltoid bursa". The provider recommended surgical intervention of the left shoulder. The treatment plan has

included the request for four lead TENS unit for indefinite use #1; conductive garment for TENS #1; Polar care unit (in days) 21; Gabapentin 600mg #180; Flexeril 7.5mg #60; and Aciphex 20mg #30. The original utilization review, dated 09-03-2015, non-certified a request for four lead TENS unit for indefinite use #1; conductive garment for TENS #1; and Aciphex 20mg #30; and modified a request for Polar care unit (in days) 21, to rental-Polar care unit for 7 day rental; Gabapentin 600mg #180, to Gabapentin 600mg #162; and Flexeril 7.5mg #60, to Flexeril 7.5mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Four lead TENS Unit for indefinite use #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: According to the California MTUS Chronic Pain Medical Treatment Guideline regarding TENS, pages 113-114, chronic pain (transcutaneous electrical nerve stimulation), "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for neuropathic pain and CRPS II and for CRPS I (with basically no literature to support use)." Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. In this case there is insufficient evidence of chronic neuropathic pain from the exam notes to warrant a TENS unit. Therefore, the determination is not medically necessary.

Conductive garment for TENS #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: According to the California MTUS Chronic Pain Medical Treatment Guideline regarding TENS, pages 113-114, chronic pain (transcutaneous electrical nerve stimulation), Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a

program of evidence-based functional restoration, for neuropathic pain and CRPS II and for CRPS I (with basically no literature to support use). Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. In this case there is insufficient evidence of chronic neuropathic pain from the exam notes to warrant a TENS unit. Therefore, the determination is not medically necessary.

Polar care unit (in days) 21: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case, the requested duration exceeds the guideline recommendations and the request is therefore not medically necessary.

Gabapentin 600mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and postherpetic neuralgia and is considered first line treatment for neuropathic pain. In this case, the exam note does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore, medical necessity has not been established.

Flexeril 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42 "Recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended." In this particular case, the patient has no evidence in the records of functional improvement, a quantitative assessment on how this medication helps, percentage of relief lasts, increase in function, or increase in activity. Therefore, chronic usage is not supported by the guidelines. Therefore, the request is not medically necessary.

Aciphex 20 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines, page 68, recommendation for Prilosec is for patients with risk factors for gastrointestinal events. The cited records do not demonstrate that the patient is at risk for gastrointestinal events. Therefore, the request is not medically necessary.