

<b>Case Number:</b>	CM15-0020382		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	10/17/2013
<b>Decision Date:</b>	04/03/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 55-year-old female who reported an injury on 10/17/2013. The mechanism of injury was not provided. There was a request for authorization submitted for review dated 01/21/2015. The diagnoses included shoulder pain and thoracic back pain, tenderness to palpation at the thoracic paraspinal muscles with related muscle spasms and myofascial restrictions, upper extremities. The documentation of 01/05/2015 revealed the injured worker had mid back, chest, and left shoulder pain. The injured worker indicated that she had significant amount of pain relief with the current medications. The injured worker was requesting a refill of all her medications. The injured worker indicated the medications allow her to increase functional mobility and do more things around the house. The injured worker indicated that the pain level without medications was 9/10 and with medications was 5/10. The injured workers pain was better with medications, standing and heat and ice. The surgical history was noncontributory. The injured workers medications included citalopram 40 mg 1 by mouth at bedtime, Norco 10/325 mg 1 tablet by mouth twice a day as needed #60, Flexeril 7.5 mg 1 tablet by mouth twice a day #60, omeprazole 20 mg 1 tablet by mouth twice a day #60 and naproxen 550 mg 1 tablet by mouth twice a day #60. The upper extremity strength was 5/5. Sensation was intact and equal bilaterally. Range of motion was diminished of the cervical spine and shoulder, thoracic spine and shoulder were diminished secondary to pain. The treatment plan included a Toradol injection, physical therapy, as it was indicated physical therapy had provided great relief and improved mobility. Additionally, the recommendation was for massage therapy 1 to 2 times a week for six weeks and the medications including citalopram 40 mg 1 by mouth at

bedtime, Norco 10/325 mg 1 tablet by mouth twice a day as needed #60, Flexeril 7.5 mg 1 tablet by mouth twice a day #60, omeprazole 20 mg 1 tablet by mouth twice a day #60 and naproxen 550 mg 1 tablet by mouth twice a day #60.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Physical Therapy 6 Visits to Thoracic Spine and Left Shoulder: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend physical medication treatment for myalgia for up to 10 visits. The clinical documentation submitted for review indicated the injured worker had prior physical medicine treatment. There was a lack of documentation of objective functional benefit that was received and remaining objective functional deficits. There was a lack of documentation indicating the quantity of sessions previously attended. Given the above, the request for Physical Therapy 6 Visits to Thoracic Spine and Left Shoulder is not medically necessary.

#### **Massage Therapy 6 Visits to Thoracic Spine and Left Shoulder: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend massage therapy that is limited to 4 - 6 visits in most cases. Massage is a passive intervention and treatment dependence should be avoided. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. The clinical documentation submitted for review failed to indicate the rationale for the use of massage and the objective examination failed to support the necessity for massage. Given the above, the request for Massage Therapy 6 Visits to Thoracic Spine and Left Shoulder is not medically necessary.

#### **Omeprazole 20 MG #60: Upheld**

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

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

**Decision rationale:** 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. The clinical documentation submitted for review failed to provide the efficacy of the requested medication. There was a lack of documentation of exceptional factors to warrant non adherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Omeprazole 20 MG #60 is not medically necessary.

**Flexeril 7.5 MG #60:** Upheld

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

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

**Decision rationale:** 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 patient has been on this medication for an extended duration of time and there was a lack of documentation of objective improvement. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant non adherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Flexeril 7.5 MG #60 is not medically necessary.