

<b>Case Number:</b>	CM15-0026619		
<b>Date Assigned:</b>	02/19/2015	<b>Date of Injury:</b>	08/23/2001
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	01/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2015

### 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: Ohio, North Carolina, Virginia  
Certification(s)/Specialty: Family Practice

### 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 51 year old female, who sustained an industrial injury on 8/23/01. She has reported pain in the left shoulder, elbow and wrist. The diagnoses have included status post left shoulder arthroscopy, left elbow strain and left De Quervain's syndrome. Treatment to date has included MRI of the left shoulder,, shoulder surgery in 12/2013, physical therapy, EMG/NCV studies and oral medications. As of the PR2 dated 12/30/14, the injured worker reports left shoulder pain that wakes her at night. The treating physician requested a left subacromial injection under ultrasound guidance, Ultram ER 150mg #30 x 2 refills and Neurontin 600mg #60 x 2 refills. On 1/21/15 Utilization Review non-certified a request for a left subacromial injection under ultrasound guidance and Neurontin 600mg #60 x 2 refills and modified a request for Ultram ER 150mg #30 x 2 refills to Ultram ER 150mg #23 x 0 refill . The utilization review physician cited the ACOEM guidelines for shoulder complaint and opioid use. On 2/11/15, the injured worker submitted an application for IMR for review of a left subacromial injection under ultrasound guidance, Ultram ER 150mg #30 x 2 refills and Neurontin 600mg #60 x 2 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Subacromial Injection Under Ultrasound Guidance: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Shoulder chapter. Steroid injections section.

**Decision rationale:** Steroid injections for the shoulder are recommended as indicated below, up to three injections. Steroid injections compared to physical therapy seem to have better initial but worse long-term outcomes. One trial found mean improvements in disability scores at six weeks of 2.56 for physical therapy and 3.03 for injection, and at six months 5.97 for physical therapy and 4.55 for injection. (Hay, 2003) Variations in corticosteroid/anesthetic doses for injecting shoulder conditions among orthopaedic surgeons, rheumatologists, and primary-care sports medicine and physical medicine and rehabilitation physicians suggest a need for additional investigations aimed at establishing uniform injection guidelines. (Skedros, 2007) There is limited research to support the routine use of subacromial injections for pathologic processes involving the rotator cuff, but this treatment can be offered to patients. Intra-articular injections are effective in reducing pain and increasing function among patients with adhesive capsulitis. Imaging guidance for shoulder injections: Glucocorticoid injection for shoulder pain has traditionally been performed guided by anatomical landmarks alone, and that is still recommended. With the advent of readily available imaging tools such as ultrasound, image-guided injections have increasingly become more routine. While there is some evidence that the use of imaging improves accuracy, there is no current evidence that it improves patient-relevant outcomes. The Cochrane systematic review on this was unable to establish any advantage in terms of pain, function, shoulder range of motion or safety, of ultrasound-guided glucocorticoid injection for shoulder disorders over either landmark-guided or intramuscular injection. They concluded that, although ultrasound guidance may improve the accuracy of injection to the putative site of pathology in the shoulder, it is not clear that this improves its efficacy to justify the significant added cost. (Bloom, 2012) Another recent meta-analysis confirms this. While there was a statistically significant difference in pain and abduction between landmark-guided and US-guided steroid injections for adults with shoulder pathology, these differences were small and do not represent clinically useful effects. (Sage, 2013) Previous studies have suggested that injections may not be reliably placed intra-articularly in the glenohumeral joint when performed in the office setting and that radiographic assistance may be necessary, but an anterior injection into the glenohumeral joint can be accurately placed without radiographic assistance using standard landmarks. (Kraeutler, 2012) (Burbank, 2008) In contrast to the higher quality Cochrane review, in this systematic review, patients who underwent image-guided (ultrasound) corticosteroid injections had statistically significant greater improvement in shoulder pain and function at six weeks after injection, compared to blind (landmark-guided) injections in adults with shoulder pain. In this instance, the injured worker does have rotator cuff tendinopathy and appears to be a good candidate for for a shoulder steroid injection. However, the submitted medical record does not state why a steroid injection utilizing standard landmarks cannot be accomplished without ultrasound guidance which is the approach recommended by the cited guidelines. Therefore, a left subacromial injection under ultrasound guidance is not medically necessary.

**Ultram ER 150 MG #30 with 2 Refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** Those prescribed opioids such as Ultram ER chronically require ongoing assessment for pain relief, functionality, medication side effects, and any aberrant drug taking behavior. Opioids may generally be continued when there is improved pain and functionality and/or the injured worker has regained employment. In this instance, pain relief and improved functionality are documented. The submitted record, however, does not contain evidence of screening for aberrant drug taking behavior such as urine drug screening or surveillance of pharmacy databases such as CURES. There is no mention of a signed opiate/pain contract on file. The requirements for chronic opioid treatment are not satisfied and consequently, Ultram ER 150 MG #30 with 2 Refills is not medically necessary per the cited guidelines.

**Neurontin 600 MG #60 with 2 Refills:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epieptic drugs.

**Decision rationale:** Anti-epileptic drugs such as Neurontin are recommended for neuropathic pain (pain due to nerve damage). Outcome: A 'good' response to the use of AEDs has been defined as a 50% reduction in pain and a 'moderate' response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the 'trigger' for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. (Eisenberg, 2007) (Jensen, 2006) After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. AEDs are associated with teratogenicity, so they must be used with caution in woman of childbearing age. Preconception counseling is recommended for anticonvulsants (due to reductions in the efficacy of birth control pills). Recommended Trial Period: One recommendation for an adequate trial with gabapentin is threeto eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin,2003) The patient should be asked at each visit as to whether there has been a change in pain orfunction. Current consensus based treatment algorithms for diabetic neuropathy suggest that if inadequate control of pain is found, a switch to another first-line drug is recommended. Combination therapy is only recommended if there is no change with first-line therapy, with the recommended change being at least 30%.In this instance, the injured worker has symptoms and physical findings suggestive of

medican and ulnar neuropathies. The gabapentin was started on 11-18-2014. Subsequently, the subjective numbness in the left hand, which was present in all fingers, was present only in 2 fingers as of 12-30-14. Pain levels diminish from 7-8/10 without medications to a 3-4/10 with medication (that also includes tramadol). Therefore, Neurontin 600 MG #60 with 2 Refills is medically necessary.