

Case Number:	CM15-0029722		
Date Assigned:	02/23/2015	Date of Injury:	10/20/1997
Decision Date:	04/06/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/17/2015

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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 61 year old male, who sustained a work related lifting injury on 10/20/97. The diagnoses have included cervical sprain, mid back sprain, bilateral shoulder impingement status post right and left shoulder surgery, right epicondylitis, right carpal tunnel syndrome, and depression. Treatments to date have included right shoulder surgery, lumbar spine surgery with donor graft, oral medications including Xanax, physical therapy, and shoulder injections. In the PR-2 dated 12/17/14, the injured worker complains of tenderness to palpation of right shoulder joint. He complains of significant headaches occurring 3 or 4 times a week. On 1/23/15, Utilization Review non-certified a request for MRI of the right shoulder without contrast. The California MTUS, ACOEM Guidelines were cited. On 1/23/15, Utilization Review modified requests for Xanax 1mg, #40 to Xanax 1mg., #30 and injection to subacromial space of the right shoulder with fluoroscopic evaluation to injection to subacromial space of the right shoulder without fluoroscopic evaluation. The California MTUS, Chronic Pain Treatment Guidelines, and ACOEM Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xanax 1mg, #40: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants- Benzodiazepines; Weaning of Medication Page(s): (s) 66, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness, Benzodiazepines.

Decision rationale: MTUS and ODG states that benzodiazepine (i.e. Lorazepam) is "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks". ODG further states regarding Lorazepam "Not recommended". Medical records indicate that the patient has been on Xanax for a period of time far exceeding MTUS recommendations. The medical record does not provide any extenuating circumstances to recommend exceeding the guideline recommendations. As such, the request for Xanax 1mg #40 is not medical necessary.

Injection to Subacromial Space of the Right Shoulder with Fluoroscopic Evaluation:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); steroid injections.

Decision rationale: MTUS states the following: "Two or three sub- Prolonged or frequent use acromial injections of cortisone injections local anesthetic and into the sub-acromial cortisone preparation space or the shoulder over an extended joint (D) period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears" has little or no evidence. ODG states the following "Criteria for Steroid injections:- Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder;- Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months;- Pain interferes with functional activities (e.g., pain with elevation is significantly limiting work);- Intended for short-term control of symptoms to resume conservative medical management- Generally performed without fluoroscopic or ultrasound guidance;- Only one injection should be scheduled to start, rather than a series of three;- A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response;- With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option;- The number of injections should be limited to three." "There is no reasoning as to why fluoroscopic guidance is required.

Therefore, the request for Injection to Subacromial Space of the Right Shoulder with Fluoroscopic Evaluation is not medically necessary.

MRI for the Right Shoulder without Contrast: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): (s) 196, 207-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI).

Decision rationale: ACOEM states "Primary criteria for ordering imaging studies are:- Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems)-Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon)-Failure to progress in a strengthening program intended to avoid surgery.-Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment)". ODG states "Indications for imaging Magnetic resonance imaging (MRI):- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs- Subacute shoulder pain, suspect instability/labral tear- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)". The treating physician documented a trial of conservative treatment in a patient older than 40 and his most recent physical exam noted a positive impingement sign on the right shoulder. As such the request for MRI OF THE right SHOULDER, NON CONTRAST is/was medically necessary.