

Case Number:	CM15-0210159		
Date Assigned:	10/29/2015	Date of Injury:	02/18/2006
Decision Date:	12/30/2015	UR Denial Date:	10/15/2015
Priority:	Standard	Application Received:	10/26/2015

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 49 year old female who sustained an industrial injury on February 18, 2006. The worker is being treated for: status post left shoulder arthroscopy and subacromial decompression; status post revision left shoulder; trapezial, paracervical, and parascapular strain and cervical segmental dysfunction. Subjective: August 26, 2015 she reported the left shoulder pain improving and she is status post three sessions of shockwave therapy. September 23, 2015 she reported "left shoulder pain, improving, "left wrist and hand pain." October 07, 2015 she reported "ongoing pain from her left neck and upper back down into shoulder." She has shoulder pain when lifting her arm in flexion of abduction and when doing horizontal abduction and adduction. Objective: June 25, 2015 noted "left shoulder anterior aspect at the AC; flexion and abduction at 90 degrees and bilateral rotations at 40 degrees. There is noted atrophy of left deltoid musculature and left shoulder swelling. August 26, 2015, September 23, 2015 noted left shoulder tender, with improved range of motion: flexion and abduction at 120 degrees, and external internal rotation at 60 degrees. The atrophy of left deltoid noted less pronounced, and diminished sensation left median nerve distribution with positive Tinel's and Phalen's: Also noted:" condition remains refractory to physical therapy as well as aqua therapy; however, shockwave therapy is indicated provided frozen shoulder and refractory nature of condition to the above and injection. "No physical therapy or injections in greater than 6 weeks." October 09, 2015 noted improved range of cervical motion with pain at end ranges. She had moderate tenderness at the base of the neck, left. There is note of moderate spasms and pain in the left trapezius muscle; also noted motion restrictions in the cervical motor units and trigger points in

the trapezius and the levator scapulae on the left. Both a cervical compression and shoulder depression tests noted positive left for localized pain. Left shoulder found with restricted range of motion in abduction and flexion. There was tenderness to palpation at the superior and posterior shoulder and a positive impingement sign. Medication: June 25, 2015, August 26, 2015, and September 23, 2015: Tramadol ER, Hydrocodone, Naproxen, Pantoprazole, Flexeril. Treatment: "status post extensive conservative care and continues to have significant residual symptoms." injections, two recent treatments of physical therapy involving cold laser therapy noted "it helped with upper back and scapular pain;" shockwave therapy to left shoulder, EMG NCV, chiropractic. On October 09, 2015 a request was made for physical therapy, left wrist and hand 12 sessions, Pantoprazole 20mg #30 which were both modified and AlignMed S3 spinal Q TLSO, Gabapentin 6% base 300GM, and Cyclobenzaprine 7.5mg #90 that were noncertified by Utilization Review on October 15, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, left wrist/hand, 12 sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Carpal Tunnel Syndrome (Acute & Chronic) - Physical medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. With regard to CTS, there is limited evidence demonstrating the effectiveness of PT or OT for CTS. The evidence may justify one pre-surgical visit for education and a home management program, or 3 to 8 visits over 3-5 weeks after surgery. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. In this case, the requested number of physical therapy sessions (12) exceeds the guideline recommendations. Medical necessity for the requested physical therapy sessions has not been established. The requested physical therapy is not medically necessary.

AlignMed S3-SpinalQ TLSO, Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic (Acute & Chronic) - Lumbar supports.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care.

Decision rationale: According to the ACOEM guidelines, lumbar binders, corsets, or support belts are not recommended as treatment for low back pain. The guidelines state that the use of back-belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security. Aligned S3 Spinal Q is a rehabilitation jacket/posture brace designed to provide scapular retention to improve postural alignment, enhance scapular function, and to relieve pain. Medical necessity for this item has not been established in this case. The requested item is not medically necessary.

Gabapentin 6% in base, 300 gms Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (for example including, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics and/or antidepressants). Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound contains: Gabapentin 6%. In this case, there is no documentation provided necessitating this compounded topical analgesic. Gabapentin is not recommended as a topical agent per CA MTUS Guidelines. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Pantoprazole 20 mg Qty 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to the California MTUS (2009) Pantoprazole (Protonix), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. There is no documentation indicating the patient had any GI symptoms or risk factors. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or

anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Based on the available information provided for review, the patient has GI issues while maintained on NSAID therapy. However, the medical necessity for Pantoprazole, taken twice per day, has not been established. The requested medication is not medically necessary.

Cyclobenzaprine 7.5 mg Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

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

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) 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. Guidelines state that 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 non-steroidal anti-inflammatory medications alone. In this case, there are no muscle spasms documented on physical exam. There is no documentation of objective functional improvement from any previous 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.