

<b>Case Number:</b>	CM15-0032139		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	01/09/2014
<b>Decision Date:</b>	04/15/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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, Hawaii

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 31-year-old female, with a reported date of injury of 01/09/2014. The diagnoses include right shoulder tendinitis and lumbar spine pain with radiation to the right lower extremity with disc herniation. Treatments have included oral medications, acupuncture, chiropractic treatment, physical therapy, an MRI of the right shoulder on 12/03/2014, and topical pain medications. The progress report dated 01/14/2015 indicates that the injured worker had right shoulder pain, rated 4 out of 10 and lumbar spine pain, rated 5 out of 10. There was popping and clicking of the right shoulder, and low back pain that radiated to the right lower extremity to the posterior knee. It was noted that there was no change in the physical examination since the last visit on 12/12/2014. The objective findings included an antalgic gait, favoring the right lower extremity. The treating physician requested chiropractic evaluation and treatment of the lumbar spine, extracorporeal shockwave therapy to the right shoulder; purchase of Solar FIR heating system and FIR heat pad, portable for the right shoulder; Norco 550mg with one refill; Prilosec 20mg with one refill; Flexeril 5mg with one refill for spasm; and CycloUltracream with one refill. The rationale for the request was not indicated. On 01/29/2015, Utilization Review (UR) denied the request for an initial chiropractic evaluation of the lumbar spine; initial chiropractic treatment twice weekly for the lumbar spine; chiropractic manipulative treatment for three to four regions, twice weekly, for the lumbar spine; chiropractic manipulative treatment for five regions, twice weekly for the lumbar spine; therapeutic procedure twice weekly for the lumbar spine; manual therapy techniques, twice weekly for the lumbar spine; infrared twice weekly for the lumbar spine; physical performance test or measurement, twice

weekly for the lumbar spine; extracorporeal shockwave therapy to the right shoulder; purchase of Solar FIR heating system and FIR heat pad, portable for the right shoulder; Norco 550mg with one refill; Prilosec 20mg with one refill; Flexeril 5mg with one refill; and CycloUltra cream with one refill. The UR physician noted that there was no documentation on the outcome of previous conservative treatment to the back; no documentation of other conservative measures being tried; the dosage for Norco was very high; no documentation of gastrointestinal issues; no evidence of lumbar spasms; and insufficient information on where the topical analgesics was to be applied and over what period of time. The MTUS Chronic Pain Guidelines and the non-MTUS Official Disability Guidelines were cited.

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

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

#### **Initial Chiropractic Evaluation lumbar spine, quantity 1: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and treatments Page(s): 58-59.

**Decision rationale:** The patient presents with pain affecting the right shoulder and low back with radiation to the right lower extremity. The current request is for Initial Chiropractic Evaluation lumbar spine, quantity 1. The treating physician report dated 2/2/15 (38C) states, "She did have eight sessions of chiropractic treatment sometime in early 2014. She states that the treatment helped to increase mobility and flexibility. She was able to continue working on modified duty after eight sessions of chiropractic treatment. She denies receiving any further chiropractic care since then". The report goes on to state, "Once again, the last course of chiropractic care my patient had was approximately one year ago, from which she did report functional improvement". MTUS guidelines states the following regarding chiropractic treatment of the low back, "Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks". MTUS goes on to recommend "an initial trial of 6-12 visits over a 2-4 week period, and, at the midway point as well as at the end of the trial, there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. If the criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow-up course of treatment may be indicated consisting of another 4-12 visits over a 2-4 week period". In this case, the patient has received a total of 8 chiropractic sessions previously and there was documentation of functional improvement such as the ability to work on modified duty. Furthermore, the request for an additional (1) initial chiropractic evaluation visit does not exceed the 18 recommended by the MTUS guidelines. Recommendation is for authorization.

#### **Initial Chiropractic Treatment twice weekly for 3 weeks of the lumbar spine: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and treatments Page(s): 58-59.

**Decision rationale:** The patient presents with pain affecting the right shoulder and low back with radiation to the right lower extremity. The current request is for Initial Chiropractic Treatment twice weekly for 3 weeks of the lumbar spine. The treating physician supplemental report dated 2/2/15 (38C) states, "She did have eight sessions of chiropractic treatment sometime in early 2014. She states that the treatment helped to increase mobility and flexibility. She was able to continue working on modified duty after eight sessions of chiropractic treatment. She denies receiving any further chiropractic care since then". The report goes on to state, "Once again, the last course of chiropractic care my patient had was approximately one year ago, from which she did report functional improvement". MTUS guidelines states the following regarding chiropractic treatment of the low back, "Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks". MTUS goes on to recommend "an initial trial of 6-12 visits over a 2-4 week period, and, at the midway point as well as at the end of the trial, there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. If the criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow-up course of treatment may be indicated consisting of another 4-12 visits over a 2-4 week period". In this case, the patient has received a total of 8 chiropractic sessions previously and there was documentation of functional improvement such as the ability to work on modified duty. Furthermore, the request for an additional 6 visits does not exceed the 18 recommended by the MTUS guidelines. Recommendation is for authorization.

**Extracorporeal shockwave therapy to the right shoulder:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, Extracorporeal shock wave therapy (ESWT).

**Decision rationale:** The patient presents with pain affecting the right shoulder and low back with radiation to the right lower extremity. The current request is for Extracorporeal shockwave therapy to the right shoulder. The treating physician request for authorization dated 1/19/15 (27B) states, "The patient underwent extensive conservative care to the diagnosed body part, which may have included but are not limited to medications, physical and manipulating therapy, injections and still was determined to have residual symptoms". The physician goes on to note that the patient suffers from a sprain/strain of the right shoulder. The MTUS guidelines do not address the current request. The ODG guidelines state the following regarding Extracorporeal shockwave therapy: "Recommended for calcifying tendinitis but not for other shoulder disorders". In this case, the patient presents with a sprain/strain of the right shoulder and the ODG guidelines only support ESWT for calcifying tendinitis. Furthermore, there is no documentation in the medical reports provided that the patient suffers from calcifying tendinitis.

The current request does not satisfy the ODG guidelines as outlined in the "Shoulder" chapter. Recommendation is for denial.

**Purchase of Solar FIR Infrared heating system and FIR Infrared Heating Pad, portable for right shoulder:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Infrared Therapy.

**Decision rationale:** The patient presents with pain affecting the right shoulder and low back with radiation to the right lower extremity. The current request is for Purchase of Solar FIR Infrared heating system and FIR Infrared Heating Pad, portable for right shoulder". The treating physician report dated 01/14/15 (31B) states, "I have prescribed the SolarCare FIR Heating System to empower my patient to become independent and to help them take a role in the management of their symptoms. The MTUS and ACOEM guidelines do not discuss Infrared therapy. The ODG guidelines under the low back chapter regarding infrared therapy states, "Not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care, exercise". ODG states a limited trial may be considered for treatment of "acute LBP". In this case, the physician is requesting a SolarCare FIR Heating System for the right shoulder and the ODG guidelines only recommend a limited trial for the treatment of acute low back pain. There is no discussion in the documents provided that the SolarCare FIR Heating System is to be used for the low back and the ODG guidelines do not support the purchase of an Infrared heating system without a successful trial. Furthermore, this heat modality is not recommended over other heat therapies. Recommendation is for denial.

**Norco 550 mg quantity 60 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Therapeutic Trial of Opioids Page(s): 91; 76-78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-94.

**Decision rationale:** The patient presents with pain affecting the right shoulder and low back with radiation to the right lower extremity. The current request is for Norco 550 mg quantity 60 with 1 refill. The treating physician report dated 1/14/15 (22C) provides no rationale for the current request. MTUS guidelines state the following regarding Initiating Opioid therapy, (a) intermittent pain: Start with a short-acting opioid trying one medication at a time. (b) Continuous pain: extended release opioids are recommended. Patients on this modality may require a dose of "rescue" opioids. The need for extra opioid can be a guide to determine the sustained release dose required. (c) Only change 1 drug at a time". The MTUS guidelines clearly state that, "Recommended Frequency of Visits While in the Trial Phase (first 6 months) is every

2 weeks for the first 2 to 4 months". The medical reports provided, do not show that the patient has previously been prescribed Norco. In this case, the current request does not satisfy MTUS guidelines as outlined on pages 76-79 as 1 refill without documentation of functional improvement is not supported. Furthermore, there is no discussion from the treating physician that the patient is to return for a check-up in 2 weeks as required by the MTUS guidelines while in the trial phase. Recommendation is for denial.

**Prilosec 20mg quantity 30 with 1 refill: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs, Gastrointestinal symptoms and cardiovascular risk Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-69.

**Decision rationale:** The patient presents with pain affecting the right shoulder and low back with radiation to the right lower extremity. The current request is for Prilosec 20mg quantity 30 with 1 refill. The treating physician report dated 1/14/15 (22C) provides no rationale for the current request. The MTUS guidelines state Omeprazole is recommended with precautions, "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)". Clinician should weigh indications for NSAIDs against GI and cardio vascular risk factors, determining if the patient is at risk for gastrointestinal events. Medical reports provided show the patient has been taking Prilosec and an NSAID in the form of Ibuprofen since at least 6/18/14 (113C). In this case, there was no indication that the patient was at risk for gastrointestinal events nor was there any documentation of dyspepsia. Furthermore, the patient does not complain of any gastrointestinal issues in any of the medical reports provided for review. The current request does not satisfy MTUS guidelines as outlined on pages 68-69. Recommendation is for denial.

**Flexeril 5mg, quantity 30 with one refill: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 64.

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

**Decision rationale:** The patient presents with pain affecting the right shoulder and low back with radiation to the right lower extremity. The current request is for Flexeril 5mg, quantity 30 with one refill. The treating physician report dated 1/14/15 (22C) provides no rationale for the current request. MTUS guidelines for muscle relaxants state the following: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use". MTUS guidelines for muscle relaxants for pain page 63 state the following: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term

treatment of acute exacerbations in patients with chronic LBP". MTUS does not recommend more than 2-3 weeks for use of this medication. Reports provided indicate that the patient has been taking this medication since at least 6/18/14 (113C). In this case, the medication is being prescribed in a small quantity that does not allow use for more than 2-3 weeks of continuous use. The current request satisfies the CA MTUS guidelines as outlined on page 63. Recommendation is for authorization.

**CycloUltracream, quantity 1 with one refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 105; 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines Pain, Compound Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The patient presents with pain affecting the right shoulder and low back with radiation to the right lower extremity. The current request is for CycloUltracream, quantity 1 with one refill. The treating physician report dated 1/14/15 (22C) provides no rationale for the current request. The MTUS guidelines have the following regarding topical analgesics: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended". The guidelines go on to state, "There is no evidence for use of any other muscle relaxant as a topical product". In this case, Cyclobenzaprine is a muscle relaxant and is not recommended as a topical product by the MTUS guidelines. Furthermore, since Cyclobenzaprine is not recommended, the requested topical compound is not recommended. Recommendation is for denial.