

Case Number:	CM15-0048262		
Date Assigned:	03/20/2015	Date of Injury:	04/06/2012
Decision Date:	05/01/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/13/2015

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, Pain Management

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 was a 64 year old female, who sustained an industrial injury, April 6, 2012. The injured worker previously received the following treatments right shoulder MRI, right knee MRI, left knee 3 or 4 injections, shoulder cortisone injection, TENS (transcutaneous electrical nerve stimulator) unit, jot and clod therapy, Tramadol, Protonix, Flexeril, LidoPro lotion, Terocin Patches, Mirtazapine, right shoulder x-ray, right knee x-ray, 12 sessions physical therapy right shoulder, arthroscopic surgery on the left knee and right shoulder. The injured worker was diagnosed with right shoulder impingement syndrome, rotator cuff strain, bicipital tendonitis, and rule out labral tear status, status post rotator cuff repair and arthroscopic surgery in January 2013, internal derangement of the left knee. According to progress note of December 3, 2014, the injured workers chief complaint was persistent right shoulder pain. The pain was aggravated by over the heads reaching, non-forceful pushing, pulling or lifting and repetitive use of the right upper extremity. The physical exam noted there was tenderness along the right shoulder, with decreased range of motion. There was tenderness along the rotator cuff and biceps tendon. The treatment plan included right knee MRI without contrast, prescriptions for Flexeril, Trazodone and Physical Therapy for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI right knee w/o contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343, algorithms 13-1 and 13-3.

Decision rationale: Regarding the request for MRI knee, CA MTUS and ACOEM note that, in absence of red flags (such as fracture/dislocation, infection, or neurologic/vascular compromise), diagnostic testing is not generally helpful in the first 4-6 weeks. After 4-6 weeks, if there is the presence of locking, catching, or objective evidence of ligament injury on physical exam, MRI is recommended. Within the medical information made available for review, there are no red flags noted and no current documentation of locking, catching, or objective evidence of ligament injury on exam. In the absence of such documentation, the currently requested MRI is not medically necessary.

Additional physical therapy 3x4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Chapter, Physical Medicine.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

Norco 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Norco (hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco (hydrocodone/acetaminophen) is not medically necessary.

Flexeril 10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

Decision rationale: Regarding the request for cyclobenzaprine (Flexeril), Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, there is no documentation of failure of first-line treatment options, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine (Flexeril) is not medically necessary.

Trazodone 50mg #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for trazodone, California MTUS guidelines are silent regarding insomnia treatment. ODG recommends the short-term use (usually two to six weeks)

of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no current description of the patient's insomnia, no discussion regarding what behavioral treatments have been attempted, and no statement indicating how the patient has responded to treatment. Furthermore, there is no indication that the medication is being used for short-term use as recommended by guidelines. In the absence of such documentation, the currently requested trazodone is not medically necessary.