MAXIMUS Federal Services

Case Number:	CM15-0070116		
Date Assigned:	04/17/2015	Date of Injury:	03/26/2013
Decision Date:	08/11/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/13/2015

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: New York
Certification(s)/Specialty: Internal 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 was a 50 year old male, who sustained an industrial injury, March 26, 2013. The injured worker previously received the following treatments lumbar epidural steroid injection, lumbar spine MRI, left knee MRI, chiropractic treatments, acupuncture, physical therapy, massage therapy, Tramadol, Ambien, Anaprox, Prilosec and random toxicology laboratory studies. The injured worker was diagnosed with left knee sprain/strain myxoid degeneration at the posterior horn of meniscus, herniated nucleus pulposus cervical spine with radiculopathy, herniated nucleus pulposus lumbar spine with radiculopathy, left shoulder sprain/strain and tendonitis with partial tear of the supraspinatus tendon, left elbow sprain/strain rule out medical and lateral epicondylitis, left wrist sprain/strain rule out carpal tunnel syndrome. According to progress note of March 10, 2015, the injured workers chief complaint was cervical spine pain, lumbar spine pain, left elbow pain, left wrist pain, left hand pain and left shoulder pain. The injured worker was status post epidural steroid injection times 2 to the lumbar spine. The physical exam noted decreased range of motion to the lumbar spine. There was paraspinal tenderness with paraspinal spasms. There was decreased range of motion of the left shoulder with subacromial grinding and clicking. There was positive impingement testing to the left shoulder. The left knee showed positive McMurray's testing. There was positive medical and lateral joint line tenderness with positive chondromalacia patella compression test. The treatment plan included ultrasound guided cortisone injection to the left shoulder and left knee and 12 physical therapy sessions for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 ultrasound guided corticosteroid injection to the left shoulder and left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chapter 9 Shoulder Complaints Page(s): 204, 339, 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic); Knee & Leg (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chapter 9 Shoulder Complaints Page(s): Shoulder Complaints Initial Care pg 204, Knee Complaints, Initial Care, pg 339. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Injection with anaesthetics and/or steroids.

Decision rationale: Per guidelines, Steroid injections injection with anaesthetics and/or steroids are recommended only as an adjunct for the short-term relief of pain in order to facilitate participation in an active rehabilitation program and restoration of functional capacity, improve function, decrease medication use, and encourage return to work. MTUS and ODG recommend subacromial injection of local anesthetic and a corticosteroid only after conservative therapy (i.e., strengthening exercises and non-steroidal anti-inflammatory drugs) for 2 - 3 weeks and if pain with elevation significantly limits activities. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. ODG recommends shoulder steroid injection for diagnoses including adhesive capsulitis, impingement syndrome, or (non-traumatic) rotator cuff problems. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. Per MTUS, invasive techniques, such as needle aspiration of effusions or prepatellar bursal fluid and cortisone injections, for the treatment of knee complains, are not routinely indicated. The injured worker complains of chronic left knee and left shoulder pain. Documentation fails to show a diagnosis that fits the guideline criteria for steroid injection. Physician report at the time of the requested service under review also fails to demonstrate that the shoulder pain severely limits activities. The request for 1 ultrasound guided corticosteroid injection to the left shoulder and left knee is not medically necessary by guidelines.

12 physical therapy sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98 - 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of Lumbar sprains and strains and Intervertebral disc disorders without myelopathy. As time goes, one should see an increase in the active regimen of care or

decrease in the passive regimen of care and a fading of treatment of frequency (from up to 3 or more visits per week to 1 or less). When the treatment duration and/or number of visits exceed the guidelines, exceptional factors should be noted. Documentation provided for review reveals that the injured worker has had previous physical therapy, but there is lack of detailed information regarding the number of visits or objective clinical outcome of the treatment. Given that the injured worker has completed an initial course of physical therapy and there is no report of significant improvement in physical function or exceptional factors, medical necessity for additional physical therapy has not been established. Per guidelines, the request for 12 physical therapy sessions is not medically necessary.

Anaprox 550mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

Decision rationale: MTUS states that Non-steroidal anti-inflammatory drugs (NSAIDS) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. There is no evidence of long-term effectiveness for pain or function. NSAIDS are recommended as a second-line treatment after acetaminophen for the treatment of acute exacerbations of chronic low back pain. The injured worker's symptoms are chronic and ongoing, without evidence of significant functional improvement or documentation of acute exacerbation. With MTUS guidelines not being met, the request for Anaprox 550mg #90 is not medically necessary.

Prilosec 20mg #45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: Proton Pump Inhibitors (PPIs) are used to treat gastrointestinal conditions such as Gastroesophageal reflux disease, Dyspepsia and Gastric ulcers, and to prevent ulcerations due to long term use of Non-steroidal anti-inflammatory drugs (NSAIDs). MTUS recommends the combination of NSAIDs and PPIs for patients at risk for gastrointestinal events, including age over 65 years of age, history of peptic ulcer, gastrointestinal bleeding, or perforation, concurrent use of ASA and high dose or multiple NSAIDs. Documentation does not support that the injured worker is at high risk of gastrointestinal events to establish the medical necessity of ongoing use of Prilosec. The request for Prilosec 20mg #45 is not medically necessary per MTUS guidelines.

Tramadol 50mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultram (Tramadol).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol Page(s): 77, 113.

Decision rationale: MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Tramadol is a centrally acting analgesic reported to be effective in managing neuropathic pain. Per MTUS guidelines, there are no long-term studies to allow use of Tramadol for longer than three months. Documentation fails to demonstrate significant improvement in pain or function, to justify the ongoing use of Tramadol. With MTUS guidelines not being met, the request for Tramadol 50mg #120 is not medically necessary.

Ambien 10mg #45: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Zolpidem (Ambien).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia treatment.

Decision rationale: Ambien (Zolpidem) is a prescription short-acting nonbenzodiazepine hypnotic, used for treatment of insomnia. Per guidelines, hypnotics are not recommended for long-term use and should be limited to three weeks maximum in the first two months of injury only. Use in the chronic phase is discouraged. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Documentation provided for review fails to show that the injured worker is diagnosed with Insomnia. Given that the injured worker has chronic pain syndrome with no documented diagnosis of sleep disorder, the medical necessity for continued use of Ambien has not been established. The request for Ambien 10mg #45 is not medically necessary based on ODG.