

Case Number:	CM14-0115474		
Date Assigned:	08/08/2014	Date of Injury:	03/05/2013
Decision Date:	10/17/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	07/23/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 46-year-old female who has submitted a claim for left shoulder impingement status post surgery, stress, depression, insomnia, gastritis, and hypertension associated with an industrial injury date 3/5/2013. The only progress report available for review was dated 7/22/2014. The patient complained of left shoulder pain associated with stiffness, popping and clicking sensation. She likewise complained of right shoulder pain, low back pain, and right great toe pain. She likewise complained of difficulty sleeping. Stiffness and tightness of paralumbar muscles were noted. Physical examination on showed tenderness at the left shoulder and paralumbar muscles. Range of motion was restricted. Impingement test and Hawkins test were positive on the left. Gait was antalgic. Treatment to date has included left shoulder arthroscopic repair on 7/31/2013, activity restrictions, and medications such as Tramadol, Flexeril, Protonix, Terocin patches, and Lidopro lotion (all since March 2014 per utilization review). Utilization review from 7/17/2014 denied the request for Tramadol ER 150 mg because of no documented objective functional improvement with medication use; denied Flexeril 7.5 mg because long-term use was not recommended; denied Protonix 20 mg because of no gastrointestinal complaints; denied Lidopro Lotion 4 ounces and Terocin patches because of limited published studies concerning its efficacy and safety and there was no evidence of failed trial of first-line therapy; denied TENS unit because of limited documentation of positive response from prior modality to use; denied EMG because of limited evidence of radiculopathy to warrant such testing; denied MR arthrogram because of insufficient clinical signs and symptoms of labral tear; denied psychiatric evaluation because of lack of information concerning severity of patient's symptoms and how it impacted activities of daily living; and denied physical therapy because documentation from prior visits were not outlined.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Tramadol since March 2014. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. The request likewise failed to specify quantity to be dispensed. Therefore, the request for Tramadol ER 150mg is not medically necessary.

Flexeril 7.5mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: According to page 41-42 of the CA MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, the patient has been on Flexeril since March 2014. However, there is no documentation concerning pain relief and functional improvement derived from its use. The request likewise failed to specify quantity to be dispensed. Therefore, the request for Flexeril 7.5mg is not medically necessary.

Protonix 20mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines TWC Pain Procedure Summary Proton Pump Inhibitors (PPIs)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms, and Cardiovascular Risk, Page(s): 68.

Decision rationale: As stated on page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be prescribed proton pump inhibitors (PPI). In this case, patient has been on Protonix since March 2014. There was a diagnosis of gastritis. However, the progress reports showed no subjective report of heartburn, epigastric burning sensation or any other gastrointestinal symptoms that may corroborate the necessity of this medication. Furthermore, patient did not meet any of the aforementioned risk factors. The guideline criteria were not met. Moreover, there is no documentation concerning pain relief and functional improvement derived from its use. The request likewise failed to specify quantity to be dispensed. Therefore, the request for Protonix 20 mg is not medically necessary.

Lidopro Lotion 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin; Topical Analgesics Page(s): 28-29; 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Topical Salicylates

Decision rationale: LidoPro lotion contains capsaicin 0.0325%, Lidocaine 4.5%, menthol 10%, and Methyl Salicylate 27.5%. CA MTUS does not cite specific provisions regarding menthol, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, Methyl Salicylate, or capsaicin, may in rare instances cause serious burns. Topical salicylate is significantly better than placebo in chronic pain as stated on page 105 of MTUS Chronic Pain Medical Treatment guidelines. Pages 111-112 further states that there is little to no research to support the use of Lidocaine for compounded products, and Lidocaine is not recommended for topical use. Moreover, there is little to no research to support the use of capsaicin 0.0325% in topical compound formulations. In this case, patient has been prescribed LidoPro lotion as adjuvant therapy to oral medications. However, guidelines state that any compounded product that contains at least one drug that is not recommended is not recommended. Lidocaine is not recommended for topical use, and capsaicin in 0.0325% formulation is likewise not recommended. Therefore, the request for LidoPro lotion 4oz is not medically necessary.

Terocin Patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine patch Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Topical Salicylate

Decision rationale: Terocin patch contains both Lidocaine and menthol. Pages 56 to 57 of CA MTUS Chronic Pain Medical Treatment Guidelines state that topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain Menthol, Methyl Salicylate, or Capsaicin, may in rare instances cause serious burns. In this case, records reviewed showed that the patient was on Terocin patch since March 2014. However, there is no evidence of trial of first-line therapy. Moreover, there is no documentation concerning pain relief and functional improvement derived from its use. The request likewise failed to specify quantity to be dispensed. Therefore, the request for Terocin Patch is not medically necessary.

TENS Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS in Chronic Pain Page(s): 114, 116.

Decision rationale: As stated on page 114 of CA MTUS Chronic Pain Medical Treatment Guidelines, TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. In this case, there is no documented rationale for a TENS unit. Medical records submitted and reviewed did not provide any evidence that patient is still continuing her home exercise program. Ongoing exercise is important since TENS is not recommended as a sole treatment modality. Moreover, as stated on page 116, a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. There was no documentation submitted regarding specific goals that should be achieved with the use of TENS. The guideline criteria have not been met. In addition, the request did not specify the duration of time for TENS therapy and body part to be treated. It is likewise unclear if the device is for rental or purchase. Therefore, the request for TENS (Transcutaneous Electrical Nerve Stimulator) unit is not medically necessary.

EMG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 537.

Decision rationale: CA MTUS ACOEM Guidelines state that electromyography (EMG) studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or

both, lasting more than three or four weeks. In this case, patient complains of bilateral shoulder pain, associated with tenderness and restricted range of motion. Impingement test and Hawkins tests were positive on the left. However, clinical manifestations were not consistent with radiculopathy to warrant EMG testing. Moreover, request failed to specify body part to be tested. Therefore, the request for EMG is not medically necessary.

MR Arthrogram: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines TWC Shoulder Procedure Summary Updated 04/25/2014

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 557-559.

Decision rationale: According to pages 557-559 of the CA MTUS ACOEM Occupational Medicine Practice Guidelines, the criteria for MR Arthrogram include a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy prior to an invasive procedure. In addition, MRI and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy although MRI is more sensitive and may be the preferred investigation because it demonstrates soft tissue anatomy better. In this case, patient complains of bilateral shoulder pain, associated with tenderness and restricted range of motion. Impingement test and Hawkins tests were positive on the left. However, there was no documented rationale for MR arthrogram. A comprehensive physical examination was not available to warrant such testing. There was no discussion that the patient was being considered a candidate for surgery. The medical necessity cannot be established due to insufficient information. Moreover, the request failed to specify body part to be tested. Therefore, the request for MR Arthrogram is not medically necessary.

Psychological Evaluation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Independent Medical Examinations and Consultations, page 127

Decision rationale: As stated on page 127 of the California MTUS ACOEM Independent Medical Examinations and Consultations Chapter, occupational health practitioners may refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. In this case, the diagnoses include stress, depression, and insomnia. However, there were no recent subjective complaints pertaining to these symptoms. Mental status examination was likewise not available to support referral to a specialist. The medical necessity cannot be established due to

insufficient information. There is no clear rationale for the requested service. Therefore, the request for psychological evaluation is not medically necessary.

Physical Therapy Qty 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Page(s): 98-99.

Decision rationale: As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. In this case, utilization review cited that patient underwent a course of physical therapy. However, the patient's response to treatment was not discussed. There was no objective evidence of overall pain improvement and functional gains derived from the treatment. Given the duration of injury, it is unclear why patient is still not versed to home exercise program to address the residual deficits. Moreover, there were no recent reports of acute exacerbation or progression of symptoms that would warrant additional course of treatment. The medical necessity has not been established. Moreover, body part to be treated is not specified. Therefore, the request for physical therapy x 12 is not medically necessary.