

Case Number:	CM14-0124329		
Date Assigned:	08/29/2014	Date of Injury:	04/25/1993
Decision Date:	09/26/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/06/2014

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 Orthopedic Surgery 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:

The claimant is a 54-year-old who was injured on 04/25/1993. The medical records provided for review included the 06/30/14 progress report describing left shoulder and upper extremity pain for which the claimant was utilizing medications. The progress report states that the claimant had recently undergone ESWT treatment with some benefit. Physical examination was documented to show acromioclavicular joint tenderness, restricted range of motion and a positive O'Brien, Hawkin's and Neer testing. Recommendation at that time was for continuation of medications to include Hydrocodone, Naprosyn, Tizanidine, Lorazepam, Ambien, Glucosamine, Omeprazole, Amitriptyline and Diclofenac. There was also a request for an acute Toradol injection for this individual. Further ESWT treatments to the left shoulder were also recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Toradol injection #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketorolac (Toradol Page(s): 72.

Decision rationale: California MTUS Chronic Pain Guidelines do not support the use of Toradol in this case. The Chronic Pain Guidelines state that Toradol has a black box warning that the medication is not indicated for minor or chronic painful conditions. This individual's injury dates back to the 1990s. There would clearly be no acute indication for an intramuscular injection of Toradol.

Condolite #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine Page(s): 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: California MTUS Chronic Pain Guidelines would not support the role of Condrolite. According to the Chronic Pain Guidelines, Condrolite is a Glucosamine and Chondroitin agent which is recommended in individuals with moderate arthritic pain, particularly the knee. The medical records in this case indicate shoulder pain with no documentation of underlying degenerative arthrosis or knee arthritis. Continued use of this agent cannot be supported.

Hydrocodone/APAP 10/325 #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids-Criteria For Use Page(s): 76-80.

Decision rationale: California MTUS Chronic Pain Guidelines would not support continued use of Hydrocodone. The Chronic Pain Guidelines recommend discontinuation of Hydrocodone if there is no overall improvement in function. The medical records provided for review do not document that the claimant has appreciated any significant benefit or advancement of claimant's treatment complaints with use of this short acting analgesic. Its acute need at this stage in claimant's clinical course for injury dating back to the 1990s would not be supported.

Tizanidine 4 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants- Tizanidine (Zanaflex) Page(s): 66.

Decision rationale: California MTUS Chronic Pain Guidelines would not support continued use of Tizanidine. This brand of muscle relaxant would not be indicated at this chronic stage in claimant's course of care. The Chronic Pain Guidelines recommend that muscle relaxants are to be utilized as second line agents with caution in the acute inflammatory process. There is no documentation that the claimant has an acute inflammatory process or indication for the use of this agent in the claimant's chronic setting. Request would not be supported as medically necessary.

TGHot 8/10/2/2/.05% topical cream 240 grams: Upheld

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

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

Decision rationale: California MTUS Chronic Pain Guidelines would not support the topical compound TG Hot. This topical compound is a combination of agents including Tramadol and Gabapentin. Both of the above agents are not currently recommended in the topical setting according to the Chronic Pain Guidelines. The Chronic Pain Guidelines state that if any one agent is not supported, the topical agent as a whole is not supported by guideline criteria.

FluriFlex cream 15%/10% 240 grams: Upheld

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

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

Decision rationale: The California MTUS Chronic Pain Guidelines would not support the request for Fluriflex. According to the Chronic Pain Guidelines, any compounded drug that contains at least one drug that is not recommended as medically necessary cannot be recommended. The Chronic Pain Guidelines further recommend that baclofen and other muscle relaxants are not recommended as a topical product. The muscle relaxant cyclobenzaprine component of the topical Fluriflex is not recommended so the entire Fluriflex is not recommended as medically necessary.

Shock-wave therapy (ECSWT) to the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Shock-wave therapy (ECSWT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

Decision rationale: California ACOEM Guidelines do not support shock wave therapy. The medical records document that the claimant has previously undergone shock wave therapy with no significant benefit. ACOEM Guidelines do not recommend the use of shock wave therapy in the shoulder because of the limited evidence of its benefit except for calcific tendinitis. The medical records do not indicate that the claimant has the diagnosis of calcific tendinitis in his shoulder.

Exercise kit with bands: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure: Home exercise kits

Decision rationale: California MTUS and ACOEM Guidelines do not provide criteria relevant to this request. Looking at Official Disability Guidelines criteria, exercise bands would not be indicated. This individual is greater than twenty years from time of injury with no current indication for need of accessories for home exercises. It would be unclear as to why this individual would not be well versed in a home exercise program without use of exercise kit for support. Clinical request would not be indicated as medically necessary.