

Case Number:	CM14-0141214		
Date Assigned:	09/22/2014	Date of Injury:	02/14/2013
Decision Date:	10/27/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	09/02/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 30 year old with a work injury dated 2/14/13. The diagnoses include right shoulder sprain. Under consideration is a request for physio therapy 2 times weekly for 4 weeks, right shoulder; Duexis Quantity: 90; Norco; Zanaflex. There is a primary treating physician report dated 6/4/14 that states that the patient complains of neck pain, rated as an 8 out of 10, that radiates into his right shoulder. There are no complaints of pain on palpation of the cervical spine or the paracervical musculature. There is no evidence of paracervical muscle spasm. Occipitocervical compression does not cause the patient to complain of pain in the upper or lower extremities. There are no complaints of pain in the neck with the ranges of motion. Examination of the patient's right shoulder reveals no evidence of deformity. The skin is intact. There is no discoloration. There is no evidence of atrophy in the shoulder girdle. Examination of the acromioclavicular joint reveals pain, but there is no step off deformity. There are complaints of pain to palpation over the bicipital groove and subacromial bursa. Range of motion of the right shoulder is full. There are complaints of pain in the right shoulder with the ranges of motion. There is no crepitus or grating. Glenohumeral rhythm is normal. Impingement sign is negative. Motor strength of the shoulders, including the rotator cuff and deltoid, is 5/5. Strength testing is performed with the shoulders in flexion, extension, abduction, adduction, internal and external rotation. The treatment plan was Cortisone injection into the right shoulder, Duexis, Norco and Zanaflex and physical therapy two times per week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physio therapy 2 times weekly for 4 weeks, right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: Physio therapy 2 times weekly for 4 weeks, right shoulder is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The documentation indicates full shoulder strength, range of motion, and glenohumeral rhythm. The medical necessity for physical therapy is not met. The request for physio therapy 2 times weekly for 4 weeks, right shoulder is not medically necessary.

Duexis Quantity: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22. Decision based on Non-MTUS Citation www.drugs.com/pro/duexis.html

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk p.69; NSAIDs (non-steroidal anti-inflammatory drugs), page 67.

Decision rationale: Duexis Quantity: 90 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. Duexis is a combination of Ibuprofen 800mg and Famotidine 26.6mg. Per MTUS guidelines Duexis is not medically necessary. There is no history that patient meets MTUS criteria for a proton pump inhibitor including : (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). California Medical Treatment Utilization Schedule Chronic Pain Guidelines do not support treatment Proton Pump Inhibitor medication in the absence of symptoms or risk factors for gastrointestinal disorders. While the MTUS does support NSAIDs in particular situations at the lowest dose for the shortest period in patients with moderate to severe pain the combination of Ibuprofen and Famotidine is not medically necessary. The request for Duexis quantity 90 is not medically necessary.

Norco: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ON-GOING MANAGEMENT; WHEN TO DISCONTINUE OPIOIDS Page(s): 78; 79-80.

Decision rationale: Norco is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates that the patient has had no evidence of functional improvement despite prior Norco use. The MTUS guidelines state to discontinue opioids if there is no overall improvement in function and pain. The request as written does not indicate a dosage or quantity. The request for Norco is not medically necessary.

Zanaflex: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN); TIZANIDINE (ZANAFLEX, GENERIC AVAILABLE) Page(s): 63; 65.

Decision rationale: Zanaflex is not medically necessary per MTUS guidelines. The MTUS recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic pain. Tizanidine (Zanaflex, generic available) is a centrally acting alpha₂-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. The documentation submitted reveals no recent evidence of spasm. The request as written does not have a dose or a time limited duration. This medication is only for short term use. The request for Zanaflex is not medically necessary.