

Case Number:	CM14-0094733		
Date Assigned:	07/25/2014	Date of Injury:	01/02/2014
Decision Date:	09/15/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/23/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 55-year-old male with date of injury of 01/02/2014. The listed diagnoses per [REDACTED] dated 03/31/2014 are: 1. Cervical thoracic sprain/arthrosis/discopathy, with central and neuroforaminal stenosis and resultant cephalgia. 2. Bilateral shoulder impingement syndrome with probable rotator cuff tears. 3. Possible bilateral carpal tunnel and/or cubital tunnel syndrome. 4. Psychiatric complaints. 5. Sleep disturbance secondary to pain. According to this report, the patient complains of neck pain radiating to the bilateral upper extremities with headaches. He reports tightness, stiffness and popping with pain in the neck. The patient complains of bilateral shoulder pain worse on the left which he describes as aching, occasionally sharp, burning, stabbing that varies in intensity and is present all the time. There are no complaints of numbness or tingling in the shoulders. The physical examination shows the patient is able to forward flex the cervical spine to touch the chin to the anterior chest. There is complaint of pain with neck motion. Spurling's test is positive bilaterally. There are complaints of tenderness to palpation over the midline of the entire cervical spine, paraspinals at those levels, and bilateral trapezii. The right shoulder has localized tenderness at the acromioclavicular joint. There are reports of pain in the acromioclavicular joint with cross body abduction. Hawkin's test is positive. Strength on external rotation is 5/5 without pain. The pain does not have scapular dyskinesis. Sulcus sign is +1. Relocation test is positive for decreased pain. Sensation to pinprick and light touch is intact in the upper extremities bilaterally. The provider references an x-ray of the cervical spine and the bilateral shoulders performed on 03/31/2014. The utilization review denied the request on 05/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk (proton pump inhibitor).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk (MTUS pg 68-69) Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007) Cardiovascular disease: A non-pharmacological choice should be the first option in patients with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short-term needs. An opioid also remains a short-term alternative for analgesia. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is naproxyn plus low-dose aspirin plus a PPI. Mild to moderate risk factors: If long-term or high-dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If naproxyn is ineffective, the suggested treatment is (1) the addition of aspirin to naproxyn plus a PPI, or (2) a low-dose Cox-2 plus ASA. Cardiovascular risk does appear to extend to all non-aspirin NSAIDs, with the highest risk found for the Cox-2 agents. (Johnsen, 2005) (Lanas, 2006) (Antman, 2007) (Laine, 2007) Use with Aspirin for cardioprotective effect: In terms of GI protective effect: The GI protective effect of Cox-2 agents is diminished in patients taking low-dose aspirin and a PPI may be required for those patients with GI risk factors. (Laine, 2007) In terms of the actual cardioprotective effect of aspirin: Traditional NSAIDs (both ibuprofen and n Page(s): 68-69.

Decision rationale: This patient presents with neck and bilateral shoulder pain. The provider is requesting omeprazole 20 mg. The MTUS Guidelines page 68 and 69 on NSAIDs, GI symptoms, and cardiovascular risks states that it is recommended with precaution to determine if patients are at risks for gastrointestinal events: (1) Ages greater than 65; (2) History of peptic ulcer, GI bleed, or perforation; (3) Concurrent use of ASA or corticosteroids and anticoagulants; and (4) High dose multiple NSAIDs. The patient was prescribed omeprazole on 03/31/2014.

The provider notes that anti-inflammatory medications cause abdominal pain. In this case, the provider documents GI symptoms as a result of medication used. This request is medically necessary.

Hydrocodone 5/325 mg: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS (MTUS 76-78)Therapeutic Trial of Opioids1) Establish a Treatment Plan. The use of opioids should be part of a treatment plan that is tailored to the patient. Questions to ask prior to starting therapy:(a) Are there reasonable alternatives to treatment, and have these been tried?(b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and subacute phases? Were there trials of other treatment, including non-opioid medications?(c) Is there likelihood of abuse or an adverse outcome? See Substance abuse (tolerance, dependence, addiction).(d) Ask about Red Flags indicating that opioids may not be helpful in the chronic phase: (1) Little or no relief with opioid therapy in the acute and subacute phases. (2) The patient has had a psychological evaluation and has been given a diagnosis of somatoform disorder. (3) The patient has been given a diagnosis in one of the particular diagnostic categories that have not been shown to have good success with opioid therapy: conversion disorder; somatization disorder; pain disorder associated with psychological factors (such as anxiety or depression).(e) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.2) Steps to Take Before a Therapeutic Trial of Opioids: (a) Attempt to determine if the pain is nociceptive or neuropathic. Also attempt to determine if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain. (b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics.(c) Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. (d) Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures.(e) Pain related assessment should include history of pain treatment and effect of pain and function. (f) Assess the likelihood that the patient could be weaned from opioids if there is no improvement in pain and function.(g) The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. When subjective complaints do not correlate with imaging studies and/or physical findings and/or when psychosocial issue concerns exist, a s Page(s): 76-78.

Decision rationale: This patient presents with neck and bilateral shoulder pain. The provider is requesting hydrocodone 5/325 mg. The MTUS Guidelines page 76 to 78 under criteria for initiating opioids, recommend that reasonable alternatives have been tried, considered the patient's likelihood of improvement, likelihood of use, etc. The records show that the patient

was prescribed Tramadol by [REDACTED] on 03/11/2014. The report dated 03/31/2014 by [REDACTED] shows that he is prescribing hydrocodone as needed for "more severe pain." MTUS supports trying different opiates for optimizing pain. For chronic use, documentations including the four A's and outcome measures are required. The trial of Hydrocodone on this patient for severe pain is medically necessary.

X-rays of the cervical spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-guidelines for Radiography(Xray, C-spine)Not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria. Initial studies may be warranted only when potentially serious underlying conditions are suspected like fracture or neurologic deficit, cancer, infection or tumor. (Bigos, 1999) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007) There is little evidence that diagnostic procedures for neck pain without severe trauma or radicular symptoms have validity and utility. (Haldeman, 2008)Indications for imaging -- X-rays (AP, lateral, etc.):- Cervical spine trauma, unconscious- Cervical spine trauma, impaired sensorium (including alcohol and/or drugs)- Cervical spine trauma, multiple trauma and/or impaired sensorium- Cervical spine trauma (a serious bodily injury), neck pain, no neurological deficit- Cervical spine trauma, alert, cervical tenderness, paresthasias in hands or feet- Cervical spine trauma, alert, cervical tenderness- Chronic neck pain (= after 3 months conservative treatment), patient younger than 40, no history of trauma, first study- Chronic neck pain, patient younger than 40, history of remote trauma, first study- Chronic neck pain, patient older than 40, no history of trauma, first study- Chronic neck pain, patient older than 40, history of remote trauma, first study- Chronic neck pain, patients of any age, history of previous malignancy, first study- Chronic neck pain, patients of any age, history of previous remote neck surgery, first study- Post-surgery: evaluate status of fusion.

Decision rationale: This patient presents with neck and bilateral shoulder pain. The provider is requesting x-rays of the cervical spine. The ACOEM Guidelines page 177 and 178 on special studies for the C-spine recommends this procedure given the following criteria: emergence of 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 invasive procedure. ODG Guidelines also states that initial studies may be warranted only when potential serious underlying conditions are suspected like fracture or neurologic deficit, cancer, infection, or tumor. For the evaluation of the patient with chronic neck pain, plain radiographs should be the initial study performed. The progress report dated 03/31/2014 notes that the patient complains of neck pain with radicular symptoms to the head with associated headaches. In the same reports, the patient is able to forward flex the cervical spine to touch the chin to the anterior chest. Spurling's test is positive bilaterally. The provider notes an x-ray of the cervical spine performed on 03/31/2014. It appears that the provider went ahead and performed the x-ray prior to UR denying the request. There is no mention of a prior set of x-ray. X-rays are allowed for initial evaluation of neck pain and is medically necessary.

X-rays of the bilateral shoulders: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Other Guidelines Official Disability Guidelines (ODG) For shoulder, ODG-guidelines Recommended as indicated below. The acutely traumatized shoulder should be imaged with plain films that are orthogonal to each other. Shoulder arthrography is still the imaging "gold standard" as it applies to full-thickness rotator cuff tears, with over 99% accuracy, but this technique must be learned, so it is not always recommended. (Newberg, 2000) Plain radiographs should be routinely ordered for patients with chronic shoulder pain, including anteroposterior, scapular Y, and axillary views. Radiographs of the acromioclavicular joint can be difficult to interpret because osteoarthritis of this joint is common by the age of 40 to 50 years. The preferred imaging modality for patients with suspected rotator cuff disorders is MRI. However, ultrasonography may emerge as a cost-effective alternative to MRI. (Burbank, 2008) Indications for imaging -- Plain radiographs:- Acute shoulder trauma, rule out fracture or dislocation- Acute shoulder trauma, questionable bursitis, blood calcium (Ca+)/approximately 3 months duration, first study.

Decision rationale: This patient presents with neck and bilateral shoulder pain. The provider is requesting x-rays of the bilateral shoulders. The ACOEM Guidelines recommends special studies on page 177 and 178 in the presence of red flags; physiologic evidence of tissue insults or neurologic dysfunction; failure to progress in the strengthening programs and clarification of anatomy prior to invasive procedure. ODG also states that plain radiographs should be routinely ordered for patients with chronic shoulder pain including anterior-posterior, scapular Y, and axillary views. It is indicated for acute shoulder trauma to rule out fracture or dislocation in questionable bursitis, blood calcium approximately 3 months in duration. The progress report dated 03/31/2014 shows a positive Hawkin's test. Strength with supraspinatus isolation is 4/5 with pain. Relocation test is positive for decreased pain. There is also report of pain at the acromioclavicular joint with cross body adduction. The provider notes an x-ray of the bilateral shoulders that was performed on 03/31/2014. It appears that the provider went ahead and performed the x-ray prior to UR denying the request. Given the patient's positive physical exam,

the requested x-ray of the bilateral shoulder is reasonable to rule out trauma or pathology. The request is medically necessary.