

Case Number:	CM15-0004900		
Date Assigned:	01/16/2015	Date of Injury:	02/13/2013
Decision Date:	03/16/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/09/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 is a 56 year old male, who sustained an industrial injury on 2/13/13. He has reported low back and shoulder pain. The diagnoses have included lumbar spine strain, impingement and right shoulder sprain. Treatment to date has included MRI, chiropractic treatments, oral medications and psychiatric treatment. As of the PR2 on 12/16/14, the injured worker reported constant right shoulder pain and an allergic reaction to the Tylenol #3 previously prescribed. The treating physician is requesting a pain management consult, a left shoulder SA injection under ultrasound guidance and Fexid #60. On 12/31/14 Utilization Review non-certified a request for a pain management consult, a left shoulder SA injection under ultrasound guidance and Fexid #60. The UR physician cited the ACOEM guidelines for low back complaints, ODG guidelines for shoulder steroid injections and MTUS guidelines for chronic pain. On 1/7/15, the injured worker submitted an application for IMR for review of a pain management consult, a left shoulder SA injection under ultrasound guidance and Fexid #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management consult: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288, 306.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulator Page(s): 105-107. Decision based on Non-MTUS Citation Spinal Cord Stimulator (SCS) UpToDate, Intractable Low Back Pain

Decision rationale: MTUS and ODG state, Recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions indicated below, and following a successful temporary trial. While Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) Type I are possible conditions for use of spinal cord stimulator, ODG and MTUS additionally clarifies that evidence is limited and more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain. The medical documents do not indicate when the most recent trial of physical therapy sessions were utilized or what other less invasive treatments have been tried with the objective results of those treatments. Additionally, no quantifying of patient's pain level or functional level was present in progress notes, which is important to assess the level of pain typically experienced by the patient to determine if the pain is intractable, per UpToDate guidelines. As such, the request for Pain management consult is not medically necessary.

(L) Shoulder SA injection under US guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Steroid injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-252. Decision based on Non-MTUS Citation Shoulder, Injections

Decision rationale: ACOEM states Two or three sub- acromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears (C, D). ACOEM C recommendation Limited research-based evidence (at least one adequate scientific study of patients with shoulder disorders). ACOEM D recommendation Panel interpretation of information not meeting inclusion criteria for research-based evidence. ODG Criteria for Steroid injections:- Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder;- Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months;- Pain interferes with functional activities (eg, pain with elevation is significantly limiting work);- Intended for short-term control of symptoms to resume conservative medical management;- Generally performed without fluoroscopic or ultrasound guidance;- Only one injection should be scheduled to start, rather than a series of three;- A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response;- With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option;- The number of injections should be limited to three The previous reviewer has approved a referral

to an orthopedic specialist in reference to this patient's shoulder complaint. Medical documentation provided does not indicate that an injection under US guidance is medically appropriate at this time. As such, the request for (L) Shoulder SA injection under US guidance is not medically necessary.

Fexmid #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Medications for chronic pain, Antispasmodics Page(s): 41-42, 60-61, 64-66. Decision based on Non-MTUS Citation Pain, Cyclobenzaprine (Flexeril; 1/2) UpToDate, Flexeril

Decision rationale: MTUS Chronic Pain Medical Treatment states for Cyclobenzaprine (FEXMID), "Recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief." The medical documents indicate that patient is far in excess of the initial treatment window and period. Additionally, MTUS outlines that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005)- Uptodate "flexeril" also recommends "Do not use longer than 2-3 weeks". Medical documents do not fully detail the components outlined in the guidelines above and do not establish the need for long term/chronic usage of cyclobenzaprine. ODG states regarding cyclobenzaprine, Recommended as an option, using a short course of therapy. The addition of cyclobenzaprine to other agents is not recommended. Other pain medications are being requested, along with cyclobenzaprine, which ODG recommends against. As such, the request for Fexmid #60 is not medically necessary.