

Case Number:	CM15-0113803		
Date Assigned:	06/22/2015	Date of Injury:	07/09/2002
Decision Date:	12/08/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	06/12/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

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

This is a 48 year old female with a date of injury on 7-9-2002. A review of the medical records indicates that the injured worker is undergoing treatment for spinal stenosis of the cervical region, spasm of muscle and disorders of bursae and tendons in the shoulder region. Medical records (3-10-2015 to 4-28-2015) indicate ongoing right shoulder pain and persistent neck pain radiating to the scapula extending to the posterior aspect of the right arm. She complained of periodic hand numbness on the right. The injured worker reported (3-10-2015) that although the oral medications were somewhat beneficial, she had done better with the Voltaren gel. Per the treating physician (3-19-2015), the employee was still working. The physical exam (3-10-2015 to 4-28-2015) reveals markedly decreased range of motion on the right. There was severe tenderness of the right paraspinous, subscapularis, suprascapular and trapezoid on the right side. Spurling's test was positive on the right. There was some tenderness over the rotator cuff. Treatment has included physical therapy, and medications (non-steroidal anti-inflammatory drugs and Voltaren gel). Per the 3-19-2015 progress report, magnetic resonance imaging (MRI) of the cervical spine dated 12-15-2014 showed degeneration and protrusion of the disc at C5-C6, C4-C5 and C6-C7. Per the 12-30-2014 progress report, electromyography (EMG)-nerve conduction velocity (NCV) of the right upper extremity dated 12-11-2014 was normal. The request for authorization dated 4-28-2015 was for physical therapy for the cervical spine, trigger point injection for the right shoulder trapezius musculature, Voltaren gel and magnetic resonance imaging (MRI) of the right shoulder. The original Utilization Review (UR) (5-11-2015) non-certified requests for physical therapy to the cervical spine, trigger point injection to the right shoulder, magnetic resonance imaging (MRI) of the right shoulder and purchase of Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy to the cervical spine 3 times a week for 2 weeks (6): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

Trigger point injections to the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Trigger Point Injections.

Decision rationale: Regarding the request for trigger point injections, Chronic Pain Medical Treatment Guidelines support the use of trigger point injections after 3 months of conservative treatment provided trigger points are present on physical examination. ODG states that repeat trigger point injections may be indicated provided there is at least 50% pain relief with reduction in medication use and objective functional improvement for 6 weeks. Within the documentation available for review, there are no physical examination findings consistent with trigger points, such as a twitch response as well as referred pain upon palpation. Additionally, there is no

documentation of failed conservative treatment for 3 months. Finally, there is no documentation of at least 50% pain relief with reduction in medication use and objective functional improvement for 6 weeks, as a result of previous trigger point injections, if any have been done. In the absence of such documentation, the requested trigger point injections are not medically necessary.

MRI of the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI).

Decision rationale: Regarding the request for repeat MRI of the shoulder, Occupational Medicine Practice Guidelines state that more specialized imaging studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines go on to recommend imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. ODG goes on to state that they repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Within the documentation available for review, the requesting physician has indicated that he is interested in obtaining an MRI to see if it is negative which would indicate that cervical spine surgery is needed. The records appear to indicate that the patient has previously had an MRI of the shoulder which was positive. It is unclear if the requesting physician has had an opportunity to review the study. Additionally, it is unclear how the patient's symptoms and findings have changed since the time of the most recent MRI. It seems reasonable to address those issues prior to requesting a 2nd MRI of the shoulder. As such, the currently requested repeat shoulder MRI is not medically necessary.

Voltaren gel 1% 100 mg 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Voltaren gel, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline

support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there's no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of Voltaren gel. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the Voltaren is for short term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Voltaren gel is not medically necessary.