

Case Number:	CM15-0121491		
Date Assigned:	07/02/2015	Date of Injury:	10/17/2008
Decision Date:	09/24/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/23/2015

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: New York
 Certification(s)/Specialty: Internal Medicine

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 44-year-old male, who sustained an industrial injury on October 17, 2008. He reported left shoulder and low back injuries. The injured worker was diagnosed as having lumbar spine musculoligamentous sprain/strain with bilateral lower extremity radiculitis and left shoulder periscapular strain, bursitis and impingement. Diagnostic studies to date have included MRIs of the left shoulder and lumbar spine and x-rays of the lumbar spine. On December 3, 2008, an MRI of the left shoulder revealed mild to moderate impingement with tendinitis, the possibility of a partial-thickness tear was not excluded, and moderate to severe hypertrophic changes of the acromioclavicular joint. On December 3, 2008, an MRI of the lumbar spine revealed a 2mm disc protrusion at thoracic 12-lumbar 1 and at lumbar 4-lumbar 5, hypertrophic facet present, patent neural foramina, and no stenosis. There was a 3mm disc protrusion in central, hypertrophic facet present, left greater than right lateral protrusion. Treatment to date has included a pain injection, chiropractic/physical therapy, acupuncture, a home exercise program, work modifications, and medications including topical analgesic, muscle relaxant, and non-steroidal anti-inflammatory. Other noted dates of injury documented in the medical record include - include the date(s) only, further details are not necessary. There were no noted previous injuries or dates of injury, and no noted comorbidities. Work status was described as regular work. On May 8, 2015, the injured worker complains of low back pain radiating to the bilateral lower extremities and left shoulder pain. The physical exam revealed tenderness to palpation with spasm over the bilateral lumbar paraspinal musculature, radiating pain to the right calf elicited by straight leg raise testing, decreased lumbar range of motion, and

decreased sensation in the right lumbar 5 dermatome. There was tenderness to palpation over the subacromial region, acromioclavicular joint, and supraspinatus of the left shoulder. The impingement and cross arm tests were positive. There was decreased range of motion and muscle strength in flexion and abduction of left shoulder. X-rays of the left shoulder and lumbar spine were obtained and interpreted as normal. Requested treatments include: Tramadol 50mg four times a day, Fexmid 7.5mg two times a day for muscle spasm, an MRI of the lumbar spine to assess disc pathology, diagnostic ultrasound study of the left shoulder to assess rotator cuff pathology, a home transcutaneous electrical nerve stimulation (TENS) unit to decrease pain and muscle spasm, x-rays of the lumbar spine, and x-rays of the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The California Medical Treatment Utilization Schedule (CMTUS) guidelines recommend the initiation of opioid therapy of intermittent pain with a short-acting opioid and trying one medication at a time. Tramadol is a synthetic short-acting opioid that affects the central nervous system, which is recommended as a second-line oral analgesic. Documentation lacks evidence of prior failed trials of first-line oral analgesics or recent urine drug screen to support compliance of treatment with Tramadol as per guidelines. The request for Tramadol 50mg #120 is not medically necessary.

Fexmid 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain.

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

Decision rationale: Per the California Medical Treatment Utilization Schedule (CMTUS) guidelines, non-sedating muscle relaxants are recommended with caution as a "second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain". The combination of muscle relaxants with non-steroidal anti-inflammatory drugs has shown no additional benefit. The efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The CMTUS guidelines recommends the antispasmodic muscle relaxant Cyclobenzaprine (Fexmid) for the short-term treatment (no longer than 2-3 weeks) to decrease muscle spasms in the lower back starting at 5mg three a day. Documentation shows clinical findings of lumbar spine paraspinal musculature spasms, which

would be appropriate for treatment with Fexmid. Per guidelines, muscle relaxants are recommended for short-term treatment. The requested prescription for 60 tablets to be taken twice a day signifies a one-month's supply, which would exceed the quantity required for short-term treatment of 2-3 weeks. The request for Fexmid 7.5mg #60 is not medically necessary.

MRI scan of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 303.

Decision rationale: MTUS recommends Lumbar spine x rays in patients with low back pain only when there is evidence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The injured worker has chronic low back pain. X-rays of the lumbar spine were obtained on May 8, 2015 and were interpreted as normal. Documentation fails to show objective clinical evidence of specific nerve compromise on the neurologic examination or acute exacerbation of the injured worker's symptoms. There is lack of Physician report indicating that surgery is being considered. The request for MRI study of lumbar spine is not medically necessary per MTUS.

Diagnostic ultrasound study of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic): Ultrasound, diagnostic (2005).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

Decision rationale: Per the ACOEM (American College of Occupational and Environmental Medicine), ultrasonography or Bone scan for evaluation of rotator cuff is not recommended. The injured worker has left shoulder pain with decreased range of motion and tenderness over the subacromial region, acromioclavicular joint, and supraspinatus. The treating physician requested an ultrasound study of the left shoulder to assess rotator cuff pathology, which is not recommended by the guidelines. The request for a diagnostic ultrasound study of the left shoulder is not medically necessary by lack of meeting guidelines.

TENS Unit (Unspecified if purchase or rental): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114; 116.

Decision rationale: Per the California Medical Treatment Utilization Schedule (MTUS) guidelines, transcutaneous electrical nerve stimulation (TENS) is recommended when there is evidence of pain of at least three months duration, trial and failure of other appropriate pain modalities (including medication), and a one-month trial period of the TENS unit as an adjunct to ongoing treatment modalities within a functional restoration approach) that includes documentation of how often the unit was used, and pain relief and function outcomes; rental would be preferred over purchase during this trial. In addition, documentation should include evidence of medication usage, a treatment plan with the specific short- and long-term goals of treatment with the TENS unit, and a two lead is generally recommended. Per the California Medical Treatment Utilization Schedule (CMTUS) guidelines, transcutaneous electrical nerve stimulation (TENS) is recommended for the treatment of chronic intractable pain for the following conditions diabetic neuropathy and post-herpetic neuralgia, phantom limb pain, complex regional pain syndrome I and II, spasticity in spinal cord injury, and multiple sclerosis pain and muscle spasm. There is lack of evidence of trial and failure of other appropriate pain modalities (including medication) and a one-month trial period of the TENS unit as an adjunct to ongoing treatment modalities within a functional restoration approach) that includes documentation of how often the unit was used, pain relief and function outcomes. The request for TENS (transcutaneous electrical nerve stimulation) patches is subsequently not medically necessary per guidelines.

X-Ray of the lumbar spine and left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 207, 303 and 308.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 9 Shoulder Complaints Page(s): 207; 303 and 309.

Decision rationale: Per the ACOEM (American College of Occupational and Environmental Medicine) guidelines, lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Per the ACOEM (American College of Occupational and Environmental Medicine) guidelines, x-rays of the shoulder are not needed unless a four- to six-week period of conservative care and observation fails to improve symptoms. The injured worker has chronic low back and left shoulder pain. Documentation fails to show red flags or evidence of specific nerve compromise on the neurologic examination to support the need for additional imaging. The request for x-ray of the lumbar spine and left shoulder is not medically necessary per MTUS.