MAXIMUS Federal Services

Case Number:	CM15-0121911		
Date Assigned:	07/06/2015	Date of Injury:	05/29/2014
Decision Date:	08/24/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	06/24/2015

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

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 female who sustained an industrial/work injury on 5/29/14. She reported an initial complaint of cervical and right shoulder pain. The injured worker was diagnosed as having right shoulder tendinitis with positive impingement test and cervical spine sprain/strain with radicular complaints and acromioclavicular osteoarthropathy. Treatment to date included medication, physical therapy, injection, acupuncture, home exercise, transcutaneous electrical nerve stimulation (TENS) unit, and ice. MRI results reported tendinopathy/tendinitis of the infraspinatus and supraspinatus. X-ray results reported on 6/1/15. Currently, the injured worker complained of right shoulder pain rated 7/10 and left shoulder and cervical pain rated 3-5/10. Per the primary physician's report (PR-2) on 5/28/15, examination revealed decreased range of motion and spasms, tenderness to the right shoulder with flexion at 130 degrees and abduction at 120 degrees. There was tenderness in the cervical spine and spasm of the right deltoid tie-in and cervical trapezius. The requested treatments include Magnetic resonance imaging (MRI) of the right shoulder, Extracorporeal shock wave therapy for the right shoulder, Hydrocodone 10/325mg, and Cyclobenzaprine 7.5mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging (MRI) of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Chapter, under Magnetic resonance imaging.

Decision rationale: This patient presents with right shoulder and neck pain. The current request is for Magnetic resonance imaging (MRI) of the right shoulder. The RFA is dated 06/11/15. Treatment to date included medication, physical therapy, injection, acupuncture, home exercise, transcutaneous electrical nerve stimulation (TENS) unit, and ice. ACOEM Guidelines has the following regarding shoulder MRI on pages 207 and 208, routine testing (laboratory test, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first 6 weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of serious shoulder condition or referred pain. ODG-TWC, Shoulder (Acute & Chronic) Chapter, under Magnetic resonance imaging (MRI) states: "Indications for imaging -- Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; Subacute shoulder pain, suspect instability/labral tear; Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." (Mays, 2008) According to progress report 05/28/15, the patient complained of right shoulder pain rated 7/10 and left shoulder and cervical pain rated 3-5/10. Examination of the right shoulder revealed flexion 90 degrees, abduction 80 degrees, positive impingement sign and positive Jobe test. The treater states most recent MRI of the right shoulder demonstrates tendinopathy/tendinitis of the infraspinatus and supraspinatus. He noted the shoulder condition is worsening and the patient has failed conservative treatment. Report 04/30/15 notes request for medically necessary updated MRI of the right shoulder. Rule out impingement/rotator cuff pathology. It appears the treater went ahead with the MRI prior to authorization. The patient had an MRI of the right shoulder on 01/23/12, which showed fluid within the subdeltoid bursa as well as some hetergenious signal seen at eh lateral margin of the greater tuberosity. There was early calcification noted and mild degenerative changes of the acromioclavicular joint. A repeat MRI of the right shoulder was done on 08/26/14 which showed AC joint degenerative changes of moderate to severe nature, impingement of the supraspinatus musculotendinous junction by the distal clavicle. In this case, there are no new injuries, no significant changes in examination, or new location of symptoms requiring additional investigation. The requested repeat MRI of the right shoulder IS NOT medically necessary.

Extracorporeal shock wave therapy for the right shoulder (5 sessions): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, ESWT.

Decision rationale: This patient presents with right shoulder and neck pain. The current request is for Extracorporeal shock wave therapy for the right shoulder (5 sessions). The RFA is dated 06/11/15. Treatment to date included medication, physical therapy, injection, acupuncture, home exercise, transcutaneous electrical nerve stimulation (TENS) unit, and ice. The MTUS Guidelines and ACOEM Guidelines do not discuss extracorporeal shock wave treatments. The ODG Guidelines under ESWT under the Shoulder Chapter states, Recommended for calcifying tendinitis, but not for other disorders, for patients with calcifying tendinitis of the shoulder in homogeneous deposits, quality evidence have found extracorporeal shock wave therapy equivalent or better than surgery and it may be given priority because of its non-invasiveness. According to progress report 05/28/15, complained of right shoulder pain rated 7/10 and left shoulder and cervical pain rated 3-5/10. Examination of the right shoulder revealed flexion 90 degrees, abduction 80 degrees, positive impingement sign and positive Jobe test. The treater states most recent MRI of the right shoulder demonstrates tendinopathy/tendinitis of the infraspinatus and supraspinatus. In addition, and there is an MRI of the right shoulder from 01/23/12, which noted early calcification. This patient presents with the required symptoms for ESWT, as ODG recommends ESWT for calcifying tendinitis. There is no indication prior trial; therefore, this request IS medically necessary.

Hydrocodone 10/325mg, #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89, 80-81.

Decision rationale: This patient presents with right shoulder and neck pain. The current request is for Hydrocodone 10/325mg, #60. The RFA is dated 06/11/15. Treatment to date included medication, physical therapy, injection, acupuncture, home exercise, transcutaneous electrical nerve stimulation (TENS) unit, and ice. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS page 77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS pages 80 and 81 also states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant Radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." This patient has been utilizing Hydrocodone since at least 04/30/15. Progress report documents decrease in pain level 4-6 points on average and the patient is able to independently participate in activities including home exercise. There was noted improved sleep quality with medications as well. The patient reports no adverse side effects. The treater states that the patient is routinely screened for aberrant and non-adherent drug-related behaviors with random

UDS. In this case, the treating physician has provided adequate documentation including the 4A's as requirement by MTUS for opiate management. The request IS medically necessary.

Cyclobenzaprine 7.5mg, #90: 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 Page(s): 63-66.

Decision rationale: This patient presents with right shoulder and neck pain. The current request is for Cyclobenzaprine 7.5mg, #90. The RFA is dated 06/11/15. Treatment to date included medication, physical therapy, injection, acupuncture, home exercise, transcutaneous electrical nerve stimulation (TENS) unit, and ice. MTUS pg. 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are Carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." The patient has been prescribed Cyclobenzaprine since at least 04/30/15. However, MTUS only recommends short-term use (no more than 2-3 weeks) for sedating muscle relaxants. The request for additional #90 would exceed MTUS recommendation and does not indicate intended short-term use. Therefore, the request IS NOT medically necessary.