

Case Number:	CM15-0124026		
Date Assigned:	07/09/2015	Date of Injury:	04/28/2005
Decision Date:	09/15/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/26/2015

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: Pediatrics, 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 56-year-old male who sustained an industrial injury on 04/28/2005. Current diagnoses include left shoulder impingement status post-arthroscopic subacromial decompression with recurrent calcification, left elbow synovitis, cervical possible referred pain, left shoulder, and status post resection of the distal clavicle of the left shoulder. Previous treatments included medications, left shoulder surgery on, and physical therapy. Report dated 04/29/2015 noted that the injured worker presented with complaints that included moderate to severe pain in the neck on the left side and left shoulder with limited range of motion, left elbow pain that radiates to the left forearm. It is noted that the injured worker is not currently in therapy, and he has 8 sessions left from the prior authorization, but has not begun therapy at this point. Pain level was not included. Physical examination was positive for slightly decreased range of motion in the neck and left shoulder. The treatment plan included recommendation for additional physical therapy, renewed prescriptions for topical creams of ketoprofen, gabapentin, tramadol, Tylenol #4, and Prilosec, a prescription for Xanax for sleeping, urine drug screen, and a prescription for X-Force Solar care device. The injured worker remains temporarily totally disabled for 6 more weeks. The documentation did not include any prior physical therapy progress notes. Disputed treatments include additional therapy sessions 3 times a week times 4 weeks, X-force solar care device for home use (TENS unit), Tylenol #4 #90, Prilosec 20mg #90, Xanax 1mg #60, and Topical Creams (Ketoprofen, Gabapentin and Tramadol).

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional therapy sessions 3 times weeks times 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The California Chronic Medical Treatment Guidelines note "that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instructions. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." The documentation submitted did not include any previous physical therapy progress notes. The physician indicated that the injured worker still has 8 visits remaining from a previous authorization "but has not begun therapy at this point". Therefore, the request for additional therapy sessions 3 times weeks times 4 weeks is not medically necessary. Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks; Postsurgical physical medicine treatment period: 6 months.

X-force solar care device for home use [tens unit]: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy; TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-115.

Decision rationale: Per MTUS guidelines, TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for neuropathic pain, phantom limb pain, spasticity and multiple sclerosis. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. The IW has none of the conditions as an indication for TENS use and is not doing physical therapy and thus the request is not medically reasonable and appropriate.

Tylenol #4 #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for the use of opioids, Opioids-long-term assessment, Weaning of Medications, Opioids specific drug list-Acetaminophen with codeine Page(s): 74-96.

Decision rationale: The California MTUS chronic pain medical treatment guidelines recommend specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. "Recommendations include the lowest possible dose be used as well as ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects. It is also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. Functional improvement means decrease in work restrictions or improvement in activities of daily living (ADLS) plus decreased dependence on medical treatment." The medical records submitted for review does not include the above- recommended documentation. There were no functional improvements noted with the use of the medications. Also, the request does not include dosing frequency or duration. Therefore, the request for Tylenol #4, #90 is not medically necessary.

Prilosec 20mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

Decision rationale: According to the California MTUS chronic pain medical treatment guidelines, there are specific guidelines for prescribing proton pump inhibitors (PPI). PPI's are recommended when patients are identified to have certain risks with the use of Non-steroidal anti-inflammatory drugs (NSAIDs). Risk factors include age > 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, and high dose/multiple NSAID. A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. The documentation provided did not indicate that the injured worker had gastrointestinal complaints. Therefore, the request for Prilosec 20mg, #90 is not medically necessary.

Xanax 1mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Alprazolam (Xanax) is a short-acting benzodiazepine drug having anxiolytic, sedative, and hypnotic properties. The medication is used in conjunction with

antidepressants for the treatment of depression with anxiety, and panic attacks. Per California MTUS Guidelines, benzodiazepines are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Most guidelines limit use to four weeks. The physician prescribed Xanax for the treatment of insomnia. Because Xanax is not recommended for the treatment of insomnia the request for Xanax 1mg #60 is not medically necessary.

Topical Creams; Ketoprofen, Gabapentin and Tramadol: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: According to the MTUS chronic pain medical treatment guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended. Ketoprofen, a non-steroidal anti-inflammatory drug (NSAID), is not currently FDA approved for topical application. It has a high incidence of photo contact dermatitis. Gabapentin is not recommended, there is no peer-viewed literature to support use. The documentation submitted did not support that the injured worker had failed a trial of oral antidepressant or antiepileptic medication and at least one of the drugs is not recommended for topical use. Also, the treating physician's request did not include the concentration, quantity, site of application, or directions for use. Therefore the request for Topical Creams; Ketoprofen, Gabapentin and Tramadol are not medically necessary.