

Case Number:	CM15-0125768		
Date Assigned:	07/10/2015	Date of Injury:	01/13/2011
Decision Date:	09/10/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	06/29/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 61 year old male, who sustained an industrial injury on January 13, 2011. He reported continuous trauma injuries of the head, ears, neck, bilateral upper extremities, internal, pulmonary, psyche, and neurological. Several documents included in the submitted medical records are difficult to decipher. The injured worker was diagnosed as having other joint derangement, chronic pain syndrome, esophageal reflux, posttraumatic chronic daily, vascular type headaches and dizziness with cognitive dysfunction, chronic myofascial pain syndrome - cervical and thoracolumbar spine, bilateral ulnar nerve entrapment at the elbows, posttraumatic tinnitus and hearing loss, and chronic bilateral shoulder sprain. Diagnostic studies to date have included: On May 26, 2011, an MRI of the left shoulder revealed a partial tear of the rotator cuff with tendinosis and moderate impingement syndrome. On January 25, 2012, an electronystagmogram revealed minor indications of vestibular difficulty. On January 12, 2012, an MRI of the cervical spine revealed multilevel disk protrusions including 2 millimeter at cervical 3-cervical 4 and cervical 5-cervical 6 and a 2.7 millimeter at cervical 4-cervical 5. The medical records refer to an MRI of the left shoulder being performed on February 13, 2015, but the results are not included in the documentation. Surgeries include: stapedectomy in 2010. Treatment to date has included thoracic trigger point injections, a home exercise program, meditation, physical therapy, chiropractic therapy, acupuncture, occipital nerve area steroid injections, a functional capacity evaluation, and medications including opioid analgesic, topical analgesic, anti-epilepsy, muscle relaxant, histamine 2 antagonist, proton pump inhibitor, anti-vertigo, and non-steroidal anti-inflammatory. Other noted dates of injury documented in the

medical record include: December 10, 1993, January 10, 1995, August 10, 1999, March 12, 2002, March 19, 2003, December 19, 2003, August 8, 2005, and June 4, 2007. Co-morbid diagnoses included history of occupational lung disease with asthma, hypertension, and heart disease. On May 28, 2015, the injured worker complained of constant neck, upper back, and lower back pain, rated 6-7/10. Associated symptoms include dizziness and tinnitus, which was aggravated. His medications improve the pain by 60-80% and improve his ability to perform his activities of daily living by 50-75%. He is not currently working. The physical exam revealed slightly decreased cervical range of motion, taut bands in the thoracic spine region, and slightly to moderately decreased lumbar range of motion. The neurological exam revealed a positive Romberg and inability to do tandem gait. The injured worker underwent 4 trigger point injections of the thoracic region. The requested treatments include: arthroscopic surgery - left shoulder; Cyclobenzaprine 7.5mg #120, Omeprazole 20mg twice a day #120, and vestibular therapy 2 times per week for 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic surgery - left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 16 Eye Chapter Page(s): 209-210.

Decision rationale: Per the MTUS / ACOEM, referral for surgical consultation may be indicated for patients who have: Red-flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.); Activity limitation for more than four months, plus existence of a surgical lesion; Failure to increase ROM and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, which involves debridement of inflamed tissue, burring of the anterior acromion, lysis and, sometimes, removal of the coracoacromial ligament, and possibly removal of the outer clavicle. A review of the injured workers medical records reveal that an MRI of the left shoulder revealed a partial tear of the rotator cuff with tendinosis and moderate impingement syndrome. He appears to have failed conservative therapy for greater than 3 months and arthroscopic decompression is appropriate at this point, therefore the request for Arthroscopic surgery - left shoulder is medically necessary.

Cyclobenzaprine 7.5mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril); Muscle Relaxants (for pain) Page(s): 41; 63-66.

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 recommend Cyclobenzaprine (Flexeril) for short-term treatment (no longer than 2-3 weeks) to decrease muscle spasms in the lower back. The medical records show that the injured worker has been taking Cyclobenzaprine since at least December 2014, which exceeds the duration recommended by the guidelines. His physical examination was positive for taut bands in the thoracic region, however it would appear that as is expected with long-term use the efficacy of Cyclobenzaprine has diminished and the continued use is not medically appropriate. Therefore, the request for Cyclobenzaprine is not medically necessary.

Omeprazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68, 69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Per the California Medical Treatment Utilization Schedule (CMTUS) guidelines, proton pump inhibitor medication is recommended when the injured worker is at intermediate or high risk for gastrointestinal events without cardiovascular disease and at high risk for gastrointestinal events with cardiovascular disease while being treated with non-steroidal anti-inflammatory drugs (NSAIDs). There is a lack of evidence that the injured worker is at intermediate or high risk for gastrointestinal events. The injured worker is being treated with Omeprazole due a history of NSAID-induced gastritis, but there is no evidence that he is taking any NSAID medication currently. In addition, there is no of documentation of the injured worker having gastrointestinal issues recently. Therefore, the Omeprazole is not medically necessary.

Vestibular therapy 2x6: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Head Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) head / Vestibular PT rehabilitation.

Decision rationale: The MTUS / ACOEM did not address the use of vestibular therapy, therefore other guidelines were consulted. Per the ODG, recommended for patients with vestibular complaints (dizziness and balance dysfunction), such as with mTBI/concussion. Vestibular rehabilitation has been shown to be associated with improvements in independence and dynamic visual acuity. (Cohen, 2006) Vestibular rehabilitation should be considered in the management of individuals post concussion with dizziness and gait and balance dysfunction that do not resolve with rest. (Alsalaheen, 2010) Vestibular complaints are the most frequent sequelae of mTBI, and vestibular physical therapy has been established as the most important treatment modality for this group of patients. (Gottshall, 2011) The use of vestibular rehabilitation for persons with balance and vestibular disorders improves function and decreases dizziness symptoms. (Whitney, 2011) A 6-month physical therapist-prescribed balance and strength home exercise program, based on the Otago Exercise Program and the Visual Health Information Balance and Vestibular Exercise Kit, significantly improved outcomes relative to the control group. (Yang, 2012) Patients with vestibular symptoms after concussion may have slower reaction times, putting them at risk for new injury compared with those who have concussions without these symptoms. A patient who is identified as having a convergence insufficiency should be prescribed in-office and home-based vision therapy designed to improve this visual deficit. In contrast, a patient identified as having predominately dizziness-related vestibular impairment from post-traumatic migraine or cervicogenic factors might be targeted with specific medications for migraine symptoms or physical therapy if it is neck-related. A review of the injured workers medical records reveal a history of head injury as well as ongoing complaints of dizziness and tinnitus corroborated on physical exam by positive romberg and inability to tandem gait, as well as electronystagmogram positive for vestibular difficulty. Based on his clinical presentation vestibular therapy would be appropriate, therefore the request for Vestibular therapy 2x6 is medically necessary.