

Case Number:	CM15-0169101		
Date Assigned:	09/15/2015	Date of Injury:	06/10/2009
Decision Date:	11/06/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	08/27/2015

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:

The injured worker is a 49 year old female, who sustained an industrial injury on 6-10-09. Medical record indicated the injured worker is undergoing treatment for internal derangement of right knee, right shoulder tendinitis-tendinopathy-calcific tendinitis, complex regional pain syndrome of right lower extremity, right wrist pain and reactive depression. Treatment to date has included 3 extracorporeal shockwave treatments, physical therapy, home exercise program, oral medications including tramadol ER 150mg, injections and activity modifications. Currently on 6-30-15 and 7-21-15, the injured worker complains of right shoulder pain rated 8 out of 10, right knee pain rated 7 out of 10 and right wrist-hand pain rated 3 out of 10. Physical exam performed on 6-30-15 and 7-21-15 revealed hyperalgesia of right knee with slightly antalgic gait and tenderness of right shoulder with swelling and slightly restricted range of motion. A request for authorization was submitted on 8-7-15 for continuation of shockwave therapy 3 sessions of left shoulder noting previously approved shockwave therapy for the shoulder has produced very good results; however the submitted documentation does not outline that the current limitations with range of motion are related to calcific tendinitis; continued request for interventional pain management noting previously approved visit provided on 6-8-15 was not submitted for review; continued request for consult for follow up with psychologist and prescriptions for Tramadol ER 150mg #60, Naproxen 550mg #90, Pantoprazole 20mg #90, Cyclobenzaprine 7.5mg #90, Prozac 20mg #60 and a urine drug screen. On 8-18-15 utilization review non-certified interventional pain management consult, shockwave therapy of right shoulder, Prozac 20mg #60 noting documentation lacks evidence of objective and functional

gains to support the subjectively reported benefit from prior use and 10 random drug screens noting partial certification of urine drug screening dated 7-1-14 was submitted for review and continued request for consult for follow up with psychologist was partially certified noting follow up psychologist is seen as medically necessary and 1 visit is allowed. Progress notes indicate that a pain management consultation is requested to manage a spinal cord stimulator. Urine drug screen was performed on February 25, 2015 and March 24, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interventional pain management consult: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Procedure Summary Online Version last updated 07/15/2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation x American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127, Other Medical Treatment Guideline or Medical Evidence: State of Colorado, Chronic Pain Disorder Medical Treatment Guidelines, Exhibit Page Number 52.

Decision rationale: Regarding the request for referral to pain management for consultation and treatment, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, it appears the patient has a spinal cord stimulator, which may need reprogramming. The requesting physician has asked for a pain management consult to evaluate and manage the spinal cord stimulator. This is a reasonable request as pain management generally manages implantable devices for the treatment of pain. Therefore, the currently requested referral to pain management is medically necessary.

Consult with follow up psychologist: Overturned

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): Behavioral interventions, Psychological evaluations, Psychological treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Behavioral Interventions.

Decision rationale: Regarding the request for Consult with follow up psychologist, Chronic Pain Medical Treatment Guidelines state that psychological evaluations are recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not

only with selected using pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury, or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. ODG states the behavioral interventions are recommended. Guidelines go on to state that an initial trial of 3 to 4 psychotherapy visits over 2 weeks may be indicated. Within the documentation available for review, it appears the patient has significant depression. Additionally, it appears the patient's primary treating physician has taken over the prescribing of antidepressant medication since the patient is in a transition phase between psychologists. Reestablishing care with a psychologist is a reasonable treatment step for a patient who is on antidepressant medications for the treatment of depression. As such, the currently requested Consult with follow up psychologist is medically necessary.

Shockwave therapy for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Shoulder Procedure Summary Online Version last updated 08/06/2015.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal Shockwave Therapy (ESWT).

Decision rationale: Regarding the request for extracorporeal shockwave therapy, Occupational Medicine Practice Guidelines support the use of extracorporeal shock wave therapy for calcified tendinitis of the shoulder. ODG further clarifies that extracorporeal shockwave therapy is recommended for calcified tendinitis of the shoulder but not for other shouldered disorders. Within the documentation available for review, it appears the patient has already undergone two ESWT sessions. However, there is no indication that the patient's range of motion has changed, despite the requesting physician indicating that the range of motion is improved with this treatment. Additionally, it is unclear how much analgesic efficacy has been obtained (in terms of percent reduction in pain, or reduction in NRS). As such, the currently requested extracorporeal shock wave therapy is not medically necessary.

Prozac 20mg Qty: 60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): Treatment, and Chronic Pain Medical Treatment 2009, Section(s): SSRIs (selective serotonin reuptake inhibitors).

Decision rationale: Regarding the request for Prozac 20mg Qty: 60, Chronic Pain Medical Treatment Guidelines state that selective serotonin reuptake inhibitors may have a role in treating secondary depression. Additionally, guidelines recommend follow-up evaluation with mental status examinations to identify whether depression is still present. Guidelines indicate that a lack

of response to antidepressant medications may indicate other underlying issues. Within the documentation available for review, it appears the patient has significant depression and has been followed by a psychologist previously. The patient is between psychological treaters, therefore the primary physician is prescribing the patient's antidepressant medication. It is acknowledged, that there is inadequate documentation of improvement as a result of this medication. However, reestablishing the patient with a psychologist should assist in clarifying that issue. As such, a one-month prescription of this medicine as requested here seems reasonable. As such, the currently requested Prozac 20mg Qty: 60 is medically necessary.

Urine toxicology screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Pain Procedure Summary last updated 06/15/2015.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: Regarding the request for a repeat urine toxicology test (UDS), CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, it appears the patient is taking controlled substance medication. The patient recently underwent a couple urine drug screens. There is no documentation of risk stratification to identify the medical necessity of drug screening at the proposed frequency. Additionally, there is no documentation that the physician has specific concerns about the patient misusing or abusing any controlled substances. In light of the above issues, the currently requested repeat urine toxicology test is not medically necessary.