

<b>Case Number:</b>	CM15-0036943		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	11/29/2000
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	02/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2015

### 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: California, Arizona

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 62-year-old male who reported an injury on 11/29/2000. The mechanism of injury was not specifically stated. The current diagnoses include right shoulder subacromial impingement with adhesive capsulitis, status post subacromial decompression on 08/08/2002, and left shoulder impingement with AC joint inflammation. The injured worker presented on 01/14/2015 for a follow-up evaluation with complaints of increased pain in the bilateral shoulders, as well as stiffness. The injured worker also reported popping, clicking, and swelling. The injured worker reported an improvement in symptoms with the use of the current medication regimen. Upon examination of the right shoulder, there was tenderness to palpation across the shoulders bilaterally, rotator cuff, and biceps tendon. There was weakness against resistance and abduction to 90 degrees bilaterally. External rotation was noted at 90 degrees with internal rotation at 60 degrees. There was 5/5 motor strength, a positive impingement sign, positive Hawkins test, positive cross arm test, and positive O'Brien's test. Treatment recommendations included continuation of the current medication regimen, as well as a TENS unit and a hot/cold wrap. An MRI of the bilateral shoulders was recommended, as well as 12 sessions of physical therapy. A Request for Authorization form was submitted on 01/14/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF or Muscle Stimulator (for purchase):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 117-121.

**Decision rationale:** The California MTUS Guidelines state that interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse or significant pain from postoperative conditions. In this case, there was no documentation of a failure of appropriate conservative management to include TENS therapy. The medical necessity for the requested interferential unit has not been established. There is also no evidence of a successful 1-month trial prior to the request for a unit purchase. Given the above, the request is not medically necessary.

**Hot & Cold Wrap (for purchase):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder, Continuous-flow cryotherapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

**Decision rationale:** California MTUS/ACOEM practice Guidelines state patients at home application of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. There was no mention of a contraindication to at home local application of heat or cold packs as opposed to a motorized mechanical device. Given the above, the request is not medically necessary.

**MRI without contrast bilateral shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. In this case, there was no documentation of an attempt at any recent conservative management prior to the request for imaging studies. As the medical necessity has not been established, the request is not medically necessary at this time.

**Physical Therapy x 12 bilateral shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulders, physical therapy; ODG Physical Therapy Guidelines.

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

**Decision rationale:** California MTUS Guidelines state 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. In this case, it is noted that the injured worker was initially treated with a course of physical therapy for the bilateral shoulders. There was no documentation of the previous course of treatment with evidence of objective functional improvement. Additional treatment would not be supported. Given the above, the request is not medically necessary.

**Vicodin 5/300mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, weaning of medications Page(s): 78-80 and 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has utilized the above medication since at least 10/2014. There is no documentation of objective functional improvement. There is no evidence of a written consent or agreement for chronic use of an opioid. Recent urine toxicology reports documenting evidence of patient compliance and non-aberrant behavior were not provided. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Flexeril 10mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants (for pain) Page(s): 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. The injured worker has

continuously utilized the above medication since at least 10/2014. Guidelines do not support long-term use of muscle relaxants. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Remeron 15mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain (updated 2/4/15), Anxiety medication in chronic pain.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Anxiety medications in chronic pain.

**Decision rationale:** According to the Official Disability Guidelines, Remeron is used to treat anxiety disorder in chronic pain patients. Remeron is considered a secondary treatment option when other medications have failed or are intolerable. In this case, the injured worker does not maintain a diagnosis of anxiety disorder. The injured worker has utilized the above medication since at least 10/2014. The medical necessity has not been established. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

**Nalfon 400mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Back pain-chronic low back pain Page(s): 67, 68 and 71.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines recommend NSAIDs for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. In this case, the injured worker is also utilizing naproxen 550 mg. The medical necessity for separate NSAIDs has not been established in this case. Guidelines do not support long term use of NSAIDs. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Tramadol ER (dosage & quantity unspecified): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids specified drug list; Tramadol (Ultram, Ultram ER; generic available in immediate release tablets); criteria for use of opioids, weaning of medications Page(s): 93, 94 and 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, there is no documentation of a written consent or agreement for the chronic use of an opioid. Recent urine toxicology reports documenting evidence of patient compliance and non-aberrant behavior were not provided. The request as submitted failed to indicate the strength, frequency, or quantity. Given the above, the request is not medically necessary.

**Lidopro Cream 1 bottle:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Salicylate topicals Page(s): 111-113 and 105.

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical lidocaine is not recommended in the form of a cream, lotion, or gel. The current request cannot be determined as medically appropriate at this time. In addition, there was no frequency listed in the request. Given the above, the request is not medically necessary.

**Norflex (dosage & quantity unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain); Antispasmodic.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, it is noted that the injured worker is also prescribed Flexeril 10 mg. The medical necessity for 2 separate muscle relaxants has not been established. The request as submitted failed to indicate the strength, frequency, or quantity. Given the above, the request is not medically necessary.

**Effexor (dosage & quantity unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13, 14 and 16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Venlafaxine (Effexor) Page(s): 123.

**Decision rationale:** California MTUS Guidelines recommend venlafaxine as an option in first line treatment of neuropathic pain. In this case, it is unclear how long the injured worker has utilized the above medication. There is no evidence of objective functional improvement. In addition, the request as submitted failed to indicate the specific strength, frequency, or quantity. Given the above, the request is not medically necessary.