

Case Number:	CM15-0046509		
Date Assigned:	03/18/2015	Date of Injury:	10/01/2014
Decision Date:	05/14/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/11/2015

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: Anesthesiology

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 38 year old female, who sustained an industrial injury on 10/01/2014. She has reported injury to the left shoulder, cervical spine, and thoracic spine. The diagnoses have included shoulder strain; chronic pain; cervical facet joint pain; and thoracic sprain/strain. Treatment to date has included medications, diagnostics, acupuncture, and chiropractic sessions. Medications have included Tramadol, Cyclobenzaprine, and Naproxen. A progress note from the treating physician, dated 01/27/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of chronic neck and bilateral shoulder pain; left shoulder/mid-back pain; the bilateral shoulder pain radiates to the bilateral arms; and joint stiffness of bilateral shoulder joints. Objective findings included cervical spine tenderness noted over the paraspinal muscles overlying the facet joints on both sides; tenderness over the left inferior angle of the left scapular region; and snapping/clicking sound with adduction of the left shoulder. The treatment plan has included injections, therapy sessions, and prescription medications. Request is being made for Bilateral C3-C4, C4-C5, C5-C6 facet injections; Six CBT sessions; series of three subscapular bursa injections on L shoulder; Orphenadrine citrate ER 100 mg; and Tramadol 50 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral C3-4, C4-C5, C5-C6 facet injections: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints Page(s): 48, Chronic Pain Treatment Guidelines Page(s): 25, 67, 119.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) and Other Medical Treatment Guidelines Neck and Upper Back (acute and chronic) Facet joint diagnostic blocks.

Decision rationale: According to ODG, cervical facet injections are limited to chronic cervical pain that is non-radicular in nature. There should not be a history of spinal stenosis or previous fusion. There should be documentation of the failure of conservative measures prior to the procedure for at least 4-6 weeks. No more than 2 levels should be injected at any one time. There should also be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. In this case, there is no documentation of any response to conservative treatments (PT, cervical traction or home exercise program). There is no specific indication for the requested service at this time. Medical necessity for the requested injections has not been established. The requested facet joint injections are not medically necessary.

Six CBT sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Intervention Page(s): 25. Decision based on Non-MTUS Citation ODG Cognitive Behavioral Therapy guidelines for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive Behavioral Therapy Page(s): 101-102, 25. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cognitive Behavioral Therapy (CBT) guidelines for chronic pain.

Decision rationale: Cognitive Behavioral Therapy (CBT) is recommended as an option for chronic pain cases. Behavioral treatment may be an effective treatment for patients with chronic neck pain, but it is still unknown what type of patients benefit most from what type of behavioral treatment. Screening should be done for patients with risk factors for delayed recovery, including fear avoidance beliefs. Initial therapy for these "at risk" patients should be physical therapy (PT) and exercise instruction, using a cognitive motivational approach to PT. A separate psychotherapy CBT referral should be considered after 4 weeks if there is lack of progress from PT alone. Initially, a trial of 3-4 psychotherapy visits would be done over 2 weeks. With evidence of objective functional improvement, a total of up to 6-10 visits over 5-6 weeks (individual sessions). Psychotherapy visits are generally separate from physical therapy visits, and psychotherapy may be appropriate after physical therapy has been exhausted. In this case, chiropractic and acupuncture treatments were prescribed, however, there is no evidence of the patient having received these interventions. In addition, PT was recommended but there is no evidence if received. There is also no documentation of psychological issues, depression or anxiety. Medical necessity for the requested CBT has not been established. The requested therapy is currently not medically necessary.

Series of three subscapular bursa injections on L shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48. Decision based on Non-MTUS Citation JAAOS Vol 15; 1, Jan 2007 page 10.

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

Decision rationale: According to the ODG, steroid injections are recommended for certain shoulder conditions. According to the medical records, this patient was noted to have pain at the tip of the left scapula and diagnosed with scapulothoracic syndrome. Left subscapular bursal injections are being requested. There is no evidence of adhesive capsulitis, impingement syndrome, or rotator cuff problems. There is also no evidence of conservative treatments tried, including PT, exercise, and/or NSAIDs. ROM of the left shoulder is normal and there is no evidence of impingement. Medical necessity for the requested injections has not been established. The requested left subscapular bursa injections are not medically necessary.

Orphenadrine citrate ER 100mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) .

Decision rationale: According to the ODG, Orphenadrine (Norflex) is a muscle relaxant similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. According to CA MTUS guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory drugs (NSAIDs) alone, and are not recommended for the long-term use of chronic pain. In this case, the patient has been prescribed NSAIDs for breakthrough pain. Based on the currently available information, the medical necessity for Orphenadrine has not been established. The requested medication is not medically necessary.

Tramadol 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 93-96.

Decision rationale: According to the California MTUS, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain; last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. In this case, it is not clear what other medications/opiates have been tried. Tramadol is not recommended as a first-line oral analgesic. Medical necessity for the requested medication has not been established. The requested treatment with Tramadol is not medically necessary.