

Case Number:	CM15-0047348		
Date Assigned:	04/14/2015	Date of Injury:	05/27/2010
Decision Date:	05/28/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/12/2015

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 37-year-old female who sustained an industrial injury on 5/27/10. The mechanism of injury was repetitive motion. The injured worker reported symptoms in the neck, shoulders and bilateral upper extremities. The injured worker was diagnosed as having discogenic cervical condition with facet inflammation and headaches, right shoulder impingement, rotator cuff strain and bicipital tendonitis and right wrist inflammation. Treatments to date have included ergonomic evaluation, physical therapy, acupuncture treatment, chiropractic treatments, activity modification, transcutaneous electrical nerve stimulation unit, oral steroids, and oral pain medication. The injured worker underwent an MRI of the right shoulder on 11/26/2012, which revealed an intact rotator cuff with no rotator cuff tearing, no labral tear and no gross internal derangement. The documentation of 02/10/2015 revealed the injured worker had pain in the neck, right shoulder and right elbow. The physical examination of the right shoulder revealed tenderness in the posterior shoulder joint with exquisite tenderness along the parascapular area and trapezius. It was noted the injured worker had not received injections for the exquisite tenderness. The injured worker had tenderness along the scalene muscles on the right. The injured worker had numbness and tingling not specifically along the ulnar distribution of the right hand with a positive Roos test. There was tenderness along the rotator cuff anteriorly. The impingement sign was equivocal. The physician indicated they were concerned about the posterior capsular pain. The injured worker has tenderness along the elbow in the olecranon area and some along the cubital tunnel area with the hyperflexion test being negative. The treatment plan included an MRI of the right

shoulder, trigger point injections of the right shoulder blade, neck traction with an air bladder, and medications including Nexium 20 mg, Norco 10 mg, Flexeril 10 mg, and tramadol 50 mg. The documentation indicated the injured worker received an elbow sleeve on the right, soft and rigid brace on the right wrist, a neck collar, neck pillow, hot and cold wrap and a TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nexium 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California MTUS guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are for the treatment of dyspepsia secondary to NSAID therapy. There was a lack of documentation indicating the injured worker had been assessed and been found to be at intermediate risk or higher for gastrointestinal events. Additionally, this request was submitted with a request for an NSAID, which is found to be not medically necessary. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Nexium 20 mg #30 is not medically necessary.

Norco 10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management opioid dosing Page(s): 60,78,86.

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation the injured worker was being monitored for aberrant drug behavior and side effects. There was a lack of documentation of objective functional improvement and an objective decrease in pain with the requested medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 10 mg #60 is not medically necessary.

MRI without contrast of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI).

Decision rationale: The Official Disability Guidelines indicate repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings of a significant pathology. The clinical documentation submitted for review indicated the injured worker had previously undergone an MRI without contrast of the right shoulder. The findings failed to indicate pathology. There was a lack of documentation indicating the injured worker had a significant change in symptoms or significant findings. Given the above, the request for MRI without contrast to the right shoulder is not medically necessary.

Trigger point injection to the right shoulder blade: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 121, 122.

Decision rationale: The California Medical Treatment Utilization Schedule recommends trigger point injections for myofascial pain syndrome and they are not recommended for radicular pain. Criteria for the use of Trigger point injections include documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; Symptoms have persisted for more than three months; Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; Radiculopathy is not present (by exam, imaging, or neuro-testing. The clinical documentation submitted for review failed to provide documentation of circumscribed trigger points with evidence upon palpation of a twitch response and referred pain. There was a lack of documentation indicating that medical management therapies including ongoing stretching exercises, physical therapy, NSAIDS and muscle relaxants have failed to control the pain. There was a lack of documentation of myotomal and dermatomal findings to support radiculopathy were not present. Given the above, the request for trigger point injection to the right shoulder is not medically necessary.

Tramadol 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60,78.

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation the injured worker was being monitored for aberrant drug behavior and side effects. There was a lack of documentation of objective functional improvement and an objective decrease in pain with the requested medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Tramadol 50 mg #60 is not medically necessary.

Nalfon 400mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS guidelines indicate that NSAIDS are recommended for short-term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain with the medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Nalfon 400 mg #60 is not medically necessary.

Flexeril 10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California MTUS guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide documentation of objective functional improvement. There were not noted to be muscle spasms upon physical examination. The duration of use could not be established. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Flexeril 10 mg #60 is not medically necessary.

Cervical traction with air bladder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Traction.

Decision rationale: The Official Disability Guidelines indicate that patient controlled traction is appropriate for use. The injured worker had Neck pain. However, there were no objective findings to support the use of cervical traction. The supplied documentation failed to indicate the rationale for the use of cervical traction. The request as submitted failed to indicate whether the unit was for rental or purchase. Given the above, the request for cervical traction with air bladder is not medically necessary.