

Case Number:	CM15-0047711		
Date Assigned:	03/19/2015	Date of Injury:	01/24/2005
Decision Date:	05/13/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/13/2015

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: Orthopedic Surgery, Sports 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 60-year-old female who reported an injury on 01/24/2005. The mechanism of injury was cumulative trauma. Prior medications included Flexeril, Zantac, and NSAIDs. There was a Request for Authorization submitted for review dated 01/26/2015. The physician documentation of 01/26/2015 revealed the injured worker had an MRI, which showed a partial rotator cuff tear. It further indicated the injured worker had trigger point injections that had been approved and the injured worker would like to have surgery on her left shoulder. The injured worker indicated her neck felt heavy and she had several trigger points. The physical examination revealed left shoulder abduction of 90 degrees, crepitation with range of motion, and tenderness of the shoulder girdle and trapezius and spasms. The diagnosis included discogenic cervical condition status post radiofrequency ablation and myofascial trigger points, right shoulder impingement status post decompression and distal clavicular excision, overuse of the right upper extremity and left shoulder, and chronic pain syndrome. The treatment plan included a hot and cold wrap, lidocaine 0.5% 1 tube, Norco 10/325 mg, Zantac 150 mg, Norflex 100 mg ER, and an arthroscopy of the left shoulder. Additionally, the documentation indicated the injured worker received a trigger point injection into the left shoulder of Depo-Medrol. The documentation of 02/25/2015 revealed a request for a left shoulder arthroscopic decompression and modified Mumford procedure with repair of labrum and biceps tendon. The unofficial results of the MRI on 08/01/2014 revealed low to moderate grade partial thickness tearing involving the anterior and middle fibers of the supraspinatus tendon and adjacent to the footprint. There was no glenoid labrum tearing. There were marked hypertrophic degenerative changes of the acromioclavicular joint with adjacent small subacromial enthesophytes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Trigger Point Injection, Left Shoulder (DOS 01/26/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

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); and there are to be no repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement. Additionally they indicate that the frequency should not be at an interval less than two months. The clinical documentation submitted for review indicated the injured worker had previously been approved for trigger point injections. It was unknown if she had undergone the injections. If the injured worker underwent the injections, there was a lack of documentation of greater than 50% pain relief for 6 weeks and there was a lack of documented functional improvement. If this was the initial request, there was a lack of documentation of circumscribed trigger points with evidence upon palpation of a twitch response and referred pain and that medical management had failed. Given the above, the request for Retrospective Trigger Point Injection, Left Shoulder (DOS 01/26/2015) is not medically necessary.

Norflex 100 mg Qty 60: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time and there is a lack of documentation of objective improvement. The clinical documentation submitted for review failed to provide documentation of exceptional factors. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norflex 100 mg QTY: 60 are not medically necessary.

Lidocaine 0.5% (tube) Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Page(s): 112.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy including AEDs, tricyclics, or SNRIs. No other commercially approved topical formulation of lidocaine including creams or gels are indicated for neuropathic pain. The clinical documentation submitted for review indicated the injured worker had neuropathic pain. However, there was a lack of documentation indicating a necessity for non-adherence to guideline recommendations. The request as submitted failed to indicate the frequency and body part to be treated. Given the above, the request for Lidocaine 0.5% (tube) Qty 1 is not medically necessary.

Zantac 150 mg Qty 30: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule recommends proton pump inhibitors for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the injured worker had utilized the medication previously. There was a lack of documented efficacy. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Zantac 150 mg QTY: 30 are not medically necessary.

Retrospective Hot and Cold Wrap (DOS 01/26/2015): Upheld

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

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

Decision rationale: The American College of Occupational and Environmental Medicine indicate that at home local applications of cold during the first few days of an acute complaint are appropriate; thereafter, heat application is appropriate. There was a lack of documentation submitted for review indicating the injured worker could not utilize at home applications of hot or cold packs. There was a lack of documentation specifically indicating a necessity for a hot and cold wrap. Given the above and the lack of documented rationale, the request for Retrospective Hot and Cold Wrap (DOS 01/26/2015) is not medically necessary.

Left Shoulder Arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 210-211.

Decision rationale: The American College of Occupational and Environmental Medicine indicates that a surgical consultation may be appropriate for injured workers who have failure to increase range of motion of the musculature around the shoulder even after exercise program, activity limitation for more than 4 months, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. The clinical documentation submitted for review indicated the injured worker had objective findings upon the unofficial MRI and physical examination. However, there was a lack of documentation of a failure of conservative care. The specific conservative care was not provided. The request as submitted failed to indicate the specific arthroscopic procedure being requested. There was no official MRI. Given the above, the request for left shoulder arthroscopy is not medically necessary.