

Case Number:	CM15-0090901		
Date Assigned:	05/15/2015	Date of Injury:	02/17/2015
Decision Date:	09/23/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/11/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 sustained an industrial injury on 2/17/15. She reported back pain, left shoulder pain, bilateral wrist/hand pain, left ankle pain and leg pain and numbness. The injured worker was diagnosed as having cervical musculoligamentous strain/sprain with radiculitis, thoracic musculoligamentous strain/sprain, lumbosacral spine discogenic disease with radiculitis, left shoulder tendinosis, bilateral wrist carpal tunnel syndrome, left thumb tenosynovitis, left thumb MCP osteoarthritis and left ankle sprain/strain. Treatment to date has included oral medications. Currently, the injured worker complains of pain in neck, mid/upper back, lower back, left shoulder, left thumb and left ankle. Physical exam noted tenderness to palpation over the cervical spine paraspinal muscles, paraspinal muscle of thoracic spine, lumbar spine, and tenderness to palpation of left shoulder, tenderness to palpation of bilateral wrists, left thumb and left ankle. A request for authorization was submitted for x-rays of cervical spine, lumbosacral spine, left shoulder, bilateral wrists and left ankle; ECSWT of left shoulder; (MRI) magnetic resonance imaging of lumbosacral spine and left shoulder; interferential unit; hot and cold unit; physical therapy evaluation and treatment of cervical spine, thoracic spine, lumbar spine, left shoulder bilateral wrists, left hand and left ankle; and Vicodin and Flexeril.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Cyclobenzaprine Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as cyclobenzaprine. The patient has been taking cyclobenzaprine for an extended period, long past the 2-3 weeks recommended by the MTUS. The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. Cyclobenzaprine 5mg #60 is not medically necessary.

Extracorporeal shock wave therapy (ESWT) of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Extracorporeal shock wave therapy (ESWT).

Decision rationale: According to the Official Disability Guidelines extracorporeal shockwave therapy is recommended only for calcifying tendinitis but not for other shoulder disorders. Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Extracorporeal shock wave therapy (ESWT) of the left shoulder is not medically necessary.

Hot and cold unit: 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), Hot/cold packs.

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

Decision rationale: Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse effects, local applications of cold packs may be applied during first few days of

symptoms followed by applications of heat packs to suit patient. Hot and cold unit is not medically necessary.

Vicodin 5/300mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

Decision rationale: According to the MTUS in regard to medications for chronic pain, only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. A record of pain and function with the medication should be recorded. According to this citation from the MTUS, medications should not be initiated in a group fashion, and specific benefit with respect to pain and function should be documented for each medication. There is no documentation of the above criteria for either of the narcotics that the patient has been taking. This patient is also currently prescribed Ultram for pain. Vicodin 5/300mg #60 is not medically necessary.

IF unit for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: According to the MTUS an interferential current stimulation (ICS) 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, and limited evidence of improvement on those recommended treatments alone. A TENS unit without interferential current stimulation is the recommended treatment by the MTUS. IF unit for the lumbar spine is not medically necessary.

MRI of the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The MTUS states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. The medical record fails to document sufficient findings indicative of nerve root compromise, which would warrant an MRI of the lumbar spine. MRI of the lumbar spine is not medically necessary.

MRI of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

Decision rationale: According to the MTUS, the primary criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure. The medical record is lacking documentation in any of the above criteria. MRI of the left shoulder is not medically necessary.