MAXIMUS Federal Services

Case Number:	CM15-0092082		
Date Assigned:	05/18/2015	Date of Injury:	02/26/2014
Decision Date:	09/23/2015	UR Denial Date:	04/25/2015
Priority:	Standard	Application Received:	05/13/2015

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: Emergency 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 73 year old female who sustained a work related injury February 26, 2014. Past history included an industrial injury to the lumbar spine in 1997, missing approximately one year of work. According to a doctor's first report of occupational injury or illness, dated April 14, 2015, the injured worker presented reporting she was injured on a day to day basis and developed cumulative trauma injuries due to repetitive movements. She complains of severe pain right shoulder, rated 8/10, radiating proximally to her neck and upper back. There is moderate pain in her left hand, rated 6/10, associated with numbness, tingling pain sensations and weakness. There is moderate pain in her neck, rated 4/10, radiating proximally to her right arm, associated with aching, dull pain sensations and stiffness. Diagnoses are full thickness tear involving the full width of the supraspinatus tendon with retraction 1.5 cm per MRI 6/26/2014; moderate osteoarthritis acromioclavicular joint; round calcification in the carpal lunar joint space/x-ray left wrist 1/15/2015; abductor pollicis longus, tenosynovitis with tendinosis, tendinitis or partial tear left wrist; C2-C3, C3-C4, C4-C5, C5-C6, C6-C7 broad based disc herniation stenosis of the spinal canal; thoracic S-shaped scoliosis; spinal cord stenosis Treatment plan included at issue, request for authorization for acupuncture, physical therapy, Gabapentin, labs, point of care urine screen, Tizanidine and Tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 physical therapy visits: 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), Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy, Manual Medicine Page(s): 58-60.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not medically necessary.

12 acupuncture visits for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

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

Decision rationale: The request is for acupuncture of the shoulder. The MTUS guidelines do not specifically address this issue. The ODG state the following: Recommended as an option for rotator cuff tendonitis, frozen shoulder, subacromial impingement syndrome, and rehab following surgery. A review of 9 trials with varying placebo controls showed there was possibly some support for short-term benefit in regards to pain and function. (Green-Cochrane, 2005) Acupuncture was of benefit over placebo in terms of function, and was more effective when combined with exercise compared to exercise alone. Several small clinical trials have found acupuncture to be effective on shoulder pain, but referral is dependent on the availability of experienced providers with consistently good outcomes. Among those shoulder indications, found to have positive outcomes from acupuncture, were rotator cuff tendonitis, frozen shoulder, subacromial impingement syndrome, and rehab following arthroscopic acromioplasty. (Kleinhenz, 1999) (Sun, 2001) (Romoli, 2000) (Nabeta, 2002) (Gilbertson, 2003) (Guerra,

2003) (He, 2004) (Vickers, 2004) (Grant, 2004) (Michener, 2004) (Guerra de Hoyos, 2004) On the other hand, a recent trial did not show any benefit of acupuncture compared with placebo TENS when added to the exercise treatment of rotator cuff tendonitis. (Razavi, 2004) The results of this trial suggest that acupuncture is more efficacious than ultrasound when applied in addition to home exercises in patients with impingement syndrome. Both groups improved, but the acupuncture group had a larger improvement in the combined score. (Johansson, 2005) This recent RCT found that either electroacupuncture or interferential electrotherapy, in combination with shoulder exercises, is equally effective in treating frozen shoulder patients. It should be noted that this study only showed the combined treatment effects with exercise as compared to no treatment, so the entire positive effect could have been due to the use of exercise alone. (Cheing, 2008) Naturopathic treatment combining acupuncture, dietary counseling, and hydrolytic enzymes was more effective than physical exercise plus placebo for treating rotator cuff tendinitis, in a recent RCT. (Szczurko, 2009) Both subacromial corticosteroid injection and a series of 10 acupuncture treatments combined with home exercises significantly decreased pain and improved shoulder function in patients with subacromial impingement syndrome. (Johansson, 2011) The latest UK Health Technology Assessment on management of frozen shoulder concludes that there was insufficient evidence to make conclusions with any certainty about the effectiveness of acupuncture for primary frozen shoulder and in what situations it is likely to be effective. (Maund, 2012) For an overview of acupuncture and other conditions in which this modality is recommended see the Pain Chapter. ODG Acupuncture Guidelines: Initial trial of 3-4 visits over 2 weeks; With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy). As stated above, there is no documentation of an initial trial of acupuncture with evidence of objective functional improvement. This would be required prior to the request submitted. As such, it is not medically necessary.

Labs to include: chem 8, hepatic function panel. CPK, CRP, arthritis panel, and CBC: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request is for laboratory testing. The MTUS guidelines state the following regarding this topic: Routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. In this case, there is documentation of a serious chronic shoulder condition. Routine screening measures including a CBC and metabolic panel as well as liver function testing is reasonable. There is inadequate explanation as to why certain blood tests have been requested, such as an arthritis panel. Pending receipt of further information, the request is not medically necessary.

Tramadol 200mg #30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid centrally acting analgesic Page(s): 80-83.

Decision rationale: Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short-term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of Tramadol for osteoarthritis is indicated for short-term use only (<3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria or indications. As such, the request is not medically necessary.

Tizanidine 6mg #30 with 1 refill: Upheld

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

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

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence for use of a muscle relaxant, the request is not medically necessary. All muscle relaxant medications should be titrated down slowly to prevent an acute withdrawal syndrome.

Point of care urine drug screen: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Criteria for Use of Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines drug screen, abuse, addiction, or poor pain control Page(s): 78.

Decision rationale: The request is for a drug screen for evaluation of illegal drug use. The MTUS guidelines state that a drug screen should be performed for patients with issues of abuse,

addiction, or poor pain control. A random screen is advised for those who are considered at high risk. In this case, the patient does not meet the qualifying factors necessary. As such, the request is not medically necessary.

Gabapentin 300mg #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin, Fibromyalgia, Weaning.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-epileptic drug (AED) Page(s): 16 and 17.

Decision rationale: The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful polyneuropathy such as in diabetes. There are few trials which have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. Their also should be documentation of functional improvement and side effects incurred with use. Disease states which prompt use of these medications include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to support use in non-specific axial low back pain or myofascial pain. In this case, there is adequate documentation of a condition which would support the use of an anti-epileptic drug.
The records do not reveal functional improvement or the screening measures as required. Pending receipt of this information, the request is not medically necessary.