MAXIMUS Federal Services

Case Number:	CM15-0093149		
Date Assigned:	05/20/2015	Date of Injury:	11/04/2007
Decision Date:	09/24/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/15/2015

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 52-year-old female, who sustained an industrial injury on 11/4/07. The injured worker was diagnosed as having impingement of right shoulder status post decompression distal clavicle excision surgery, discogenic cervical condition, chronic pain and inactivity and carpal tunnel syndrome and wrist inflammation. Treatment to date has included right shoulder arthroscopy followed by open rotator cuff repair, activity restrictions, cervical collar and pillow, hot/cold wrap, TENS unit, back brace and oral medications including Norco, Flexeril, Docuprene, Gabapentin, Naproxen sodium and Prilosec and topical Fentanyl patches. (MRI) magnetic resonance imaging of cervical spine revealed C4-5 and C5-6 disc bulge and (EMG) Electromyogram/ (NCV) Nerve Condition Velocity studies of upper extremities revealed chronic right C7 radiculopathy and generalized polyneuropathy. Currently, the injured worker complains of persistent neck pain as well as right shoulder pain, low back pain and right wrist pain. She is currently not working. Physical exam noted tenderness along the cervical paraspinal muscles as well as right shoulder with limited range of motion and slow, guarded gait. A request for authorization was submitted for continuation of medications: Norco, Flexeril, Docuprene, Gabapentin and Prilosec and topical Fentanyl patches, referral to pain management, hot/cold wrap, soft brace and an injection to subacromial space.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold Wrap: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

Decision rationale: The request is for the use of hot or cold treatment to be applied topically to aid in pain relief. The ACOEM guidelines under Physical Methods states that during the acute to subacute phase of injury over the first 2 weeks, application of hot or cold can be effective in ameliorating symptoms. This would aid in facilitation of mobility and exercise. Due to the longstanding duration after injury, continued use would not be indicated in this case. As such, the request is not medically necessary.

Right Shoulder Subacromial Injection under Fluoroscopy: Overturned

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

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 and Chronic) Chapter.

Decision rationale: The request is for an injection in the shoulder to aid in pain relief. The ODG guidelines state the following regarding this topic: Criteria for Steroid injections: Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder. Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months. Pain interferes with functional activities (eg, pain with elevation is significantly limiting work). Intended for short-term control of symptoms to resume conservative medical management. Generally performed without fluoroscopic or ultrasound guidance. Only one injection should be scheduled to start, rather than a series of three. A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response. With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option. The number of injections should be limited to three. In this case, the patient does qualify for the requested treatment as defined in the criteria above. This is to aid in partial resolution of her symptoms and improve function. As such, the request is medically necessary.

Referral for Pain Management: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic) Chapter, Office visits.

Decision rationale: The request is for a specialty consultation. The MTUS guidelines are silent regarding this issue. The ODG state the following: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. See also Telehealth. In this case, the request is medically necessary. This is secondary to ongoing chronic pain beyond what would be expected and need for consultation for pain evaluation. There is adequate discussion of the specific issue requiring further evaluation and assessment.

Trazodone 50mg, #60: Upheld

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

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

Decision rationale: The request is for the use of the medication trazodone. This is a medication in the category of a serotonin agonist and reuptake inhibitor and is used for depression. It also has anxiolytic and sedative hypnotic effects. The MTUS guidelines are silent regarding its use. The ODG guidelines state that this medication is indicated as an option for insomnia for patients with coexisting depression or anxiety. Its use as a first-line treatment for primary insomnia is not advised. Evidence for the off-label use of trazodone for treatment of insomnia is poor. The current recommendation is to use a combined

pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. In this case, there is inadequate documentation of a psychiatric evaluation revealing comorbid factors which would qualify the patient for use of trazodone as a first-line agent. As such, the request is not medically necessary.

Neurontin 600mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs) Page(s): 16-17.

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. There 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 also do not reveal functional improvement or screening measures as required. As such, the request is not medically necessary.

Protonix 20mg, #60: Upheld

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

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

Decision rationale: The request is for the use of a medication in the class of a proton pump inhibitor. This is usually given as an acid reducing medication for patients with esophageal reflux, gastritis, or peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)". Due to the fact the patient does not meet to above stated criteria, the request for use is not medically necessary.

Flexeril 7.5mg, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical

evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) 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.

Nalfon 400mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: The request is for the use of NSAIDS to aid in pain relief. NSAIDS are usually used to aid in pain and inflammation reduction. The MTUS guidelines states that for osteoarthritis NSAIS are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen especially for patients with moderate to severe pain. There is no evidence to support one drug in this class over another based on efficacy. In particular, there appears to be no difference between NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects, with COX-2 NSAIDs having fewer GI side effects at the risk of increased cardiovascular side effects. The FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain and function. (Chen, 2008) (Laine, 2008) For back pain, NSAIDS are recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective that acetaminophen for acute LBP. (Van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007) In this case, there is inadequate documentation of functional improvement to justify continued use, as the guidelines recommend the lowest dose for the shortest period of time. The significant side effect profile of medications in this class put the patient at risk when used chronically. As such, the request is not medically necessary.

Fentanyl 25mg, #10: Upheld

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

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

Decision rationale: The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement which should eventually lead to medication discontinuation. The records also do not reveal screening measures as discussed above for continued use of a medication in the opioid class. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

Norco 120: Upheld

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

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

Decision rationale: The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement which should eventually lead to medication discontinuation. The records also do not reveal screening measures as discussed above for continued use of a medication in the opioid class. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.