

Case Number:	CM15-0095270		
Date Assigned:	05/21/2015	Date of Injury:	10/26/2010
Decision Date:	06/24/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/18/2015

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: Connecticut, California, Virginia
 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 53 year old male, who sustained an industrial injury on 10/26/2010. He reported pain to the low back, neck, and bilateral shoulders. The injured worker was diagnosed as having bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, cervical spine sprain/strain, lumbar spine sprain/strain, bilateral shoulder sprain/strain, and excessive weight gain. Treatment to date has included medications, magnetic resonance imaging (3/21/2015), and urine toxicology. The request is for a back brace, on steroid injection to the shoulder, and Norco. On 3/21/2015, he complained of low back pain. The pain is not described, and severity is not indicated. Physical findings revealed tenderness of the lumbar spine with a decreased painful range of motion. The range of motion is not described. The treatment plan included: Flexeril, Norco, home exercise program, Ibuprofen, and Methoderm. On 4/8/2015, he complained of pain to the right shoulder, left shoulder, and low back. The provider indicated magnetic resonance imaging of the bilateral shoulder revealed acromioclavicular osteoarthritis, and a magnetic resonance imaging of the lumbar spine showed annular tear. There are no other objective findings noted. The treatment plan included: back brace, refill Norco, bilateral elbow sleeves, steroid injection to the shoulder, and pain management. The records contain several handwritten documents which are difficult to decipher.

IMR ISSUES, DECISIONS AND RATIONALES

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

Back brace, quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, lumbar supports.

Decision rationale: The MTUS states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The ODG recommend lumbar bracing as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). In this case, there is not good evidence in the provided documents to support use of a back brace given the very low likelihood of clinical improvement based on the guidelines, and therefore the request is not considered medically necessary at this time.

Norco 10/325mg, quantity: 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Utilization Review reasonably modified the request to facilitate appropriate weaning. Given the lack of evidence to support functional improvement on the medication and the chronic risk of continued treatment, the request for Norco is not considered medically necessary.

Steroid injection to the shoulder, quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

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

Decision rationale: The ODG guidelines provide a detailed mechanism with which to evaluate for corticosteroid injections of the shoulder. Criteria for injections include: 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. Overall in this case, the provided documents indicate that the patient has pain in the shoulder, but it is unclear whether or not the patient has failed conservative treatment and what shoulder diagnosis the patient is actually carrying. Therefore it cannot be determined that the patient meets the criteria set by the guidelines and the request is not medically necessary at this time without increased clarity in the diagnosis and clinical presentation.