

Case Number:	CM13-0001799		
Date Assigned:	05/02/2014	Date of Injury:	11/02/2011
Decision Date:	07/15/2014	UR Denial Date:	07/02/2013
Priority:	Standard	Application Received:	07/17/2013

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. The expert reviewer is Board Certified in Anesthesiology and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 62-year-old male with a date of injury of 11/12/2011. The patient's diagnoses include left shoulder adhesive capsulitis and rotator cuff partial tear. The patient's complaints include stiffness, weakness and aching with tingling and numbness in the left index and middle fingers, frequent pain and numbness in the left arm and moderate neck pain. The pain is rated as constant and 8/10.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE LEFT WRIST/HAND: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269-270.

Decision rationale: According to the patient's medical record, there is a request for an MRI of the left wrist/hand to "r/o ID and r/o tendinitis CTS". Although these abbreviations are somewhat ambiguous, they are generally interpreted to mean - rule out internal derangement and tendinitis, Carpal Tunnel Syndrome of the left wrist/hand. According to the MTUS/ACOEM guidelines, and MRI has very little ability to identify and define wrist and hand pathology. Carpal Tunnel

Syndrome is successfully diagnosed in the majority of patients by electrodiagnostic testing. An MRI is not considered first line imaging to rule out pathology of the wrist and hand. It may be considered under certain circumstances although other imaging modalities, such as x-ray, should be considered before an MRI. Therefore, the above listed issues are considered to be not medically necessary.

TWELVE TO EIGHTEEN (12-18) PHYSICAL THERAPY SESSIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-210, Chronic Pain Treatment Guidelines Pain Interventions and Treatment Page(s): 10-18. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Guidelines, Shoulder (Acute & Chronic).

Decision rationale: In a note dated 02/01/2012, there is documentation of minimal progress with physical therapy three (3) times a week, with continued limited range of motion. As of 03/04/2013, there is reportedly continued stiffness, weakness and constant aching. Documentation of previous physical therapy from 2012 reveals little to no improvement with several documented physical therapy sessions. A physical examination reveals continued limited range of motion. The MTUS guidelines generally recommend physical therapy in the post-surgical period; however, there is no recent documented report of a surgical procedure for this patient. The Official Disability Guidelines have more extensive guidelines regarding physical therapy. In general, the most important factor for both the MTUS and the Official Disability Guidelines is evidence of functional improvement. In this patient, there is no specific mention of functional improvement as a result of previous physical therapy regimen in 2012. In this case, the patient should be formally assessed after a "six-visit clinical trial" to determine if physical therapy should be continued. Also, according to the Official Disability Guidelines, home programs should be initiated with the first session and an on-going assessment of compliance, in order to facilitate fading of treatment. Therefore, the above listed issue is considered to be not medically necessary.

TIZANIDINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/antispasmodic drugs, Tizanidine; Topical analgesics Page(s): 66 and 111.

Decision rationale: Tizanidine is a muscle relaxant. According to the Chronic Pain Guidelines, it is utilized for management of spasticity and for myofascial pain syndrome. It may also provide benefit in fibromyalgia. There is no documented evidence of physical examination findings of spasticity, myofascial pain syndrome or fibromyalgia. Therefore, the above listed issue is considered to be not medically necessary.

TRAMADOL: Overturned

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): 74-96.

Decision rationale: Tramadol is a synthetic opioid. The Chronic Pain Guidelines indicate that in general, opioids are considered to be effective in reducing the intensity of pain. Tramadol is indicated for short term pain relief. Previous documentation indicates Motrin was helping to relieve pain, but has increasingly become less effective. Tramadol has been proven effective in decreasing the intensity of pain and producing symptom relief on a short term basis. In general, opioids are considered to be effective in reducing the intensity of pain. For on-going management with opioid medications, recommendations include assessment of current pain, least reported pain over a period since last assessment, average pain, intensity of pain after taking opioid, time to pain relief and duration of relief with opioid. The Chronic Pain Guidelines also recommend consideration of a multidisciplinary pain clinic consultation if pain does not improve on opioids in three (3) months. In addition, there should be documentation of the lowest dose necessary for the improvement of pain. The above listed issue is considered to be medically necessary.

OMEPRAZOLE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69.

Decision rationale: The Chronic Pain Guidelines indicate that Omeprazole is a proton pump inhibitor, which should be considered in patients at either intermediate or high risk for gastrointestinal events. There is no documented evidence of gastrointestinal risk factors or symptoms in this patient. Therefore, the above listed issue is considered to be not medically necessary.