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| Case Number: | CM13-0052809 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 12/06/2012 |
| Decision Date: | 05/02/2014 | UR Denial Date: | 11/01/2013 |
| Priority: | Standard | Application Received: | 11/16/2013 |

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 Pain Management and is licensed to practice in Florida. 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:

The injured worker is a 49-year-old female who reported an injury on 12/03/2012. The mechanism of injury involved a fall. The injured worker is diagnosed with left shoulder partial supraspinatus tendon tear at the distal attachment, left shoulder impingement with bursitis, left shoulder AC degenerative joint disease, bilateral wrist synovial/ganglion cyst, neck and mid-back pain, history of left carpal tunnel release, right hip sacroiliac joint dysfunction, right hip degenerative joint disease, right shoulder bursitis and impingement, and moderate to severe symptomatic AC degenerative joint disease with calcific tendonitis. The injured worker was seen by [REDACTED] on 09/13/2013. The injured worker reported bilateral shoulder, left wrist/hand, and right hip pain. The injured worker reported improvement with acupuncture and chiropractic therapy. Physical examination of the right shoulder revealed tenderness to palpation over the AC joint, positive impingement bursitis, positive O'Brien's testing, and 4/5 external rotation strength. Physical examination of the right hip revealed positive Faber testing, positive compression and distraction testing, and positive Gaenslen's testing. The treatment recommendations at that time included a prescription for Terocin pain patch, Hydrocodone 7.5/325 mg, chiropractic therapy, an MRI of the right shoulder and right hip, x-rays of the right hip and right shoulder, and a 30-day trial of TENS unit with supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI OF THE RIGHT SHOULDER AND RIGHT HIP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Magnetic Resonance Imaging.

Decision rationale: California MTUS/ACOEM Practice Guidelines state primary criteria for ordering imaging studies of the shoulder includes the emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program, or for clarification of the anatomy prior to an invasive procedure. As per the documentation submitted, the injured worker's physical examination of the right shoulder revealed tenderness to palpation with positive impingement bursitis and O'Brien's testing. There is no documentation of the emergence of any red flags. There is also no mention of an exhaustion of conservative treatment or a failure to progress in a strengthening program. The medical necessity for the requested procedure has not been established. Furthermore, Official Disability Guidelines state indications for an MRI of the hip includes osseous, articular, or soft tissue abnormality; osteonecrosis; occult, acute, and stress fracture; acute and chronic soft tissue injury, or tumor. The injured worker does not meet any of the above-mentioned criteria as outlined by the Official Disability Guidelines. The injured worker's physical examination of the right hip only revealed positive Faber testing, positive compression and distraction testing, and positive Gaenslen's testing. There is no mention of an attempt at conservative treatment for the right hip prior to the request for an imaging study. There were no plain films obtained prior to the request for an MRI. The medical necessity for the requested service has not been established. Based on the clinical information received, the request is non-certified.

30 DAY TRIAL OF TENS UNIT WITH SUPPLIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 117-121.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered as a noninvasive conservative option. There should be documentation of a failure to respond to other appropriate pain modalities, including medication. As per the documentation submitted, the injured worker has reported improvement in symptoms and function following acupuncture and chiropractic therapy. While it is noted that the injured worker found benefit with the use of TENS therapy during chiropractic therapy and acupuncture, there was no objective evidence of improvement, or documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

X-RAYS OF THE RIGHT SHOULDER AND RIGHT HIP: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, X-Ray.

Decision rationale: California MTUS/ACOEM Practice Guidelines state for most patients presenting with shoulder problems, special studies are not needed unless a 4 to 6-week period of conservative care and observation fails to improve symptoms. Official Disability Guidelines state plain radiographs of the pelvis should routinely be obtained in patients sustaining a severe injury. X-rays are also valuable for identifying patients with a high risk of developing hip osteoarthritis. The injured worker does not appear to meet any of the above-mentioned criteria. There is no indication of a severe injury. There is also no indication that this injured worker is at high risk of developing hip osteoarthritis. There was also no documentation of at least 4 to 6 weeks of conservative treatment for the right shoulder prior to the request for an x-ray. The medical necessity has not been established. Therefore, the request is non-certified.

1 BOX OF TEROGIN PAIN PATCHES #10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Lidocaine is indicated for neuropathic pain or localized peripheral pain after there has been evidence of a trial of first-line therapy. As per the documentation submitted, there is no evidence of a trial of first-line therapy with tricyclic or SNRI antidepressants or an anticonvulsant. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

HYDROCODONE/APAP 7.5/325MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and

documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the injured worker has continuously utilized Norco 7.5/325 mg. Although the injured worker noted improvement in pain and an increase in function, there was no objective evidence of functional improvement as a result of the ongoing use of this medication. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.