

Case Number:	CM13-0056006		
Date Assigned:	12/30/2013	Date of Injury:	05/26/1999
Decision Date:	03/25/2014	UR Denial Date:	11/15/2013
Priority:	Standard	Application Received:	11/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Medicine and is licensed to practice in Arizona. 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 physician 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:

Patient is a 52 year old female with a date of injury on 11/6/1994. Patient has been treated for ongoing left shoulder, and right knee/ankle/foot pain. Patient has had previous right leg reconstruction right ankle surgery, low back surgery, left knee surgery, and right shoulder surgery. Medications include metformin, glipizide, enalapril, Celebrex, Januvia, diclofenac, pioglitazone, Zantac, estradiol, spironolactone, hydrocodone, Flexeril, and Ambien. Patient has diagnoses of rotator cuff tear demonstrated on MRI from 6/13. Subjective complaints found in the medical documentation are of left knee pain, 7/10 and left shoulder pain with decreased range of motion. Objective exam findings include global left shoulder pain with weakness to external rotation. There was no identified documentation that demonstrated right leg, knee, or ankle complaints or physical exam. Patient had left knee and tibia/fibula x-rays in 2/13 which were normal. Previous treatments for shoulder include physical therapy, injections and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

x-ray of the left shoulder provided on 10/9/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 214.

Decision rationale: According to ODG and ACOEM guidelines, shoulder x-rays are indicated if there has been an acute shoulder trauma. Indications for plain films include acute shoulder trauma to rule out fracture or dislocation or acute shoulder trauma with questionable bursitis. This patient has chronic shoulder pain and has documented MRI findings of a rotator cuff tear. There is no evidence of acute fracture, dislocation or signs of acute bursitis. Therefore, the medical necessity of a left shoulder x-ray is not established.

x-ray of the left humerus provided on 10/9/1: 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) Elbow, (Acute and Chronic), Radiography.

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

Decision rationale: ODG only suggests x-ray of the elbow (distal humerus) if there is suspicion of osteochondral fracture, osteochondritis dissecans, or intra-articular body. Patients with normal elbow range of motion do not require x-rays. The proximal humerus is covered by a shoulder x-ray which is only indicated with acute shoulder trauma to rule out fracture or dislocation. For this patient, the medical records did not reveal any subjective humerus/elbow complaint or physical findings that would support a humerus x-ray. Therefore, the medical necessity of a humerus x-ray is not established.

x-ray of the right knee provided on 10/9/13: 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) Knee and Leg (Acute and Chronic) Radiograph

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

Decision rationale: ODG guidelines recommend knee radiographs for injuries due to trauma, knee fractures, tenderness at the head of the fibula or patella and inability to bear weight, or inability to flex the knee to 90 degrees. For this patient the medical records were without subjective complaint of right knee pain or knee physical examine, or any mention of recent acute trauma. Due to lack of documentation and guideline recommendations for knee x-rays only with recent trauma, the medical necessity of this study is not established.

x-ray of the right tibia/fibula provided on 10/9/13: 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) Ankle and Foot (Acute and Chronic) Radiograph

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

Decision rationale: ODG recommends ankle x-rays (distal tib/fib) if there is inability to bear weight after injury, point tenderness over the lateral or medial malleolus, talus or calcaneus, inability to ambulate for four steps, or chronic ankle pain with suspicion of ankle instability. The proximal tibia/fibula would be included in a knee x-ray series of which the ODG only recommends knee radiographs for injuries due to trauma, knee fractures, tenderness at the head of the fibula or patella and inability to bear weight, or inability to flex the knee to 90 degrees. The medical record does not identify any subjective complaints or objective findings that document any ongoing or acute lower leg problem. The medical necessity of a tibia/fibula x-ray is not established.

x-ray of the right ankle provided on 10/9/13: 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) Ankle and Foot (Acute and Chronic) Radiograph

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

Decision rationale: The ODG recommends ankle x-rays if there is inability to bear weight after injury, point tenderness over the lateral or medial malleolus, talus or calcaneus, inability to ambulate for four steps, or chronic ankle pain with suspicion of ankle instability. For this patient, there is no documentation of subjective or objective findings of the lower leg issues. Therefore, due to lack of documentation of lower leg complaints the medical necessity of ankle x-rays are not established.

x-ray of the right foot provided on 10/9/2013: 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) Ankle and Foot (Acute and Chronic) Radiograph

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

Decision rationale: The ODG recommends x-rays of the foot if there is inability to bear weight after injury. Also, if there is chronic foot pain with heel pain, burning pain, paresthesia,

tenderness over the second metatarsal, or pain along the aspect of the heel. This patient had no evidence of pain, swelling, or tenderness in the foot. There is no physical examination recorded for the foot or clinical reasoning presented. Therefore, the medical necessity for a foot x-ray is not established.

hydrocodone/APAP 10/325mg #60 dispensed on 10/9/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-91.

Decision rationale: CA Chronic Pain Guidelines indicate that hydrocodone/acetaminophen is indicated for moderate to moderately severe pain. Opioids may be continued if there is improvement in function and pain or if the patient has returned to work. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. The medical records do not indicate significant pain relief or functional improvement from taking hydrocodone for this patient. Since guidelines do not suggest long-term opioid use without outcome measures and documented functional improvement, the medical necessity of hydrocodone/acetaminophen is not established.

pantoprazole sodium 20mg #60 dispensed on 10/9/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Issues Page(s): 68.

Decision rationale: According to CA MTUS guidelines, a proton pump inhibitor (PPI) can be added to NSAID therapy if the patient is at an intermediate to high risk for adverse GI events. Guidelines identify the following as risk factors for GI events: age >65, history of peptic ulcer, GI bleeding or perforation, use of ASA, corticosteroids, anticoagulant use, or high dose NSAIDS. There was evidence of some prior GI disturbance, but this was as the result of taking Celebrex. There is no further documentation identified that would stratify this patient in an intermediate or high risk GI category. ODG guidelines recognize the similar chemical structure and efficacy of various PPIs. Due to these similarities, and significant cost savings, a trial of Prevacid or Prilosec is recommended before a second line therapy such as pantoprazole (Protonix). Since there is no documented trial of first line PPIs, and patient is not in an intermediate or high risk GI category the medical necessity of pantoprazole is not established.

cyclobenzaprine 7.5mg #90 dispensed on 10/9/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Muscle Relaxants .

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Cyclobenzaprine, Muscle Relaxants Page(s): 41-42, 63.

Decision rationale: CA MTUS guidelines indicate that the use of cyclobenzaprine should be used as a short term therapy, and the effects of treatment are modest and may cause adverse affects. This patient had been using cyclobenzaprine chronically, which is longer than the recommended course of therapy of 2-3 weeks. There is no evidence in the documentation that suggests the patient experienced improvement with the ongoing use of cyclobenzaprine. Due to clear guidelines suggesting cyclobenzaprine as short term therapy and no clear benefit from adding this medication the requested prescription for cyclobenzaprine is not medically necessary.