MAXIMUS Federal Services

Case Number:	CM14-0101689		
Date Assigned:	07/30/2014	Date of Injury:	09/16/1995
Decision Date:	10/06/2014	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	07/01/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 45 year old gentleman was reportedly injured on September 16, 1995. The mechanism of injury is noted as rolling down a hill in a railcar. The most recent progress note, dated July 10, 2014, indicates that there are ongoing complaints of low back pain, right knee pain, and right shoulder pain. The injured employee currently rated his pain as 8/10. The physical examination demonstrated tenderness along the temporomandibular joints, tenderness along the cervical spine musculature on the right side and the trapezius muscle, right shoulder also revealed tenderness and decreased abduction limited to 100 degrees, positive Tinel's sign at the right elbow and muscular wasting along the thenar and hypoesthesia are muscles bilaterally decreased sensation was present at the third, fourth, and fifth digits of the right hand and fourth and fifth digits of the left hand, positive right sided Tinel's test at the wrist, lumbar spine noted tenderness along the paravertebral muscles and palpable trigger points throughout, decreased lumbar spine range of motion and pain with facet loading, right knee tenderness at the anterior joint line with mild swelling and crepitus with range of motion, tenderness also along the left knee at the medial and lateral joint lines. Diagnostic imaging studies of the right knee revealed degenerative arthritis and postsurgical changes. An MRI the cervical spine noted a disc protrusion and facet hypertrophy at C4 to C5, C5 to C6, and C7 to T1. There was a 3 mm disc protrusion at C6 to C7. A CT of the lumbar spine showed significant loss of disc height at L4 to L5 with facet hypertrophy and lateral recess stenosis. Treatment includes a left below knee amputation, a right shoulder arthroscopy for a rotator cuff repair, a right knee arthroscopy with a posterior cruciate ligament repair, and a lumbar facet rhizotomy. A request was made for an intrathecal morphine pump and an MR arthrogram of the right knee and was not certified in the preauthorization process on June 5, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intrathecal Morphine Pump: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52-54.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Implantable Drug Delivery System, Updated September 24, 2014.

Decision rationale: According to the Official Disability Guidelines the criteria for permanently implanted intrathecal infusion pump includes documentation of failure of other conservative treatment modalities to include pharmacological methods, further surgical intervention is not likely, a psychological evaluation has been obtained, and there has been successful temporary trial. A review of the medical record does not indicate that the injured employee meets these requirements. As such, this request for an intrathecal morphine pump is not medically necessary.

Right Knee MR Arthrogram: 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) 12th Edition Web, Knee and Leg MR Arthrogram

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, MRI, Updated August 25, 2014.

Decision rationale: A review of the medical record indicates that the injured employee has had a previous right knee MRI performed on March 5, 2008 which was stated to have been obscured by considerable magnetic susceptibility artifact and therefore a CT was recommended. A right knee CT was performed on October 13, 2010 and on November 3, 2011. Considering this, an MR arthrogram of the right knee is not medically necessary.

Right Shoulder MR Arthrogram: 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) 12th Edition (WEB), Shoulder

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, MR Arthrogram, Updated August 27, 2014.

Decision rationale: According to the Official Disability Guidelines the indication for an MR arthrogram of the shoulder is an option to detect labral tears or for suspected re-tear of a postoperative rotator cuff repair. The progress note dated July 10, 2014 does not have any physical examination findings indicative of a labral tear. Additionally, the injured employee has good strength and abduction is limited by pain which does not indicate a re-tear of the rotator cuff. As such, this request for a right shoulder MR arthrogram is not medically necessary.