

Case Number:	CM14-0111883		
Date Assigned:	08/01/2014	Date of Injury:	09/16/1995
Decision Date:	09/10/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/17/2014

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, has a subspecialty in Interventional Spine 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:

The patient is a 44 year old with an injury date on 9/16/95. Patient complains of ongoing low lumbar mostly axial in natural, occasionally radiating down to bilateral hips/left posterior thigh, pain rated 7/10 per 6/12/14 report. Patient has continuing right knee and right shoulder pain, and requires Oxycontin and Norco for breakthrough pain and normal activities of daily living per 6/12/14 report. Based on the 6/12/14 progress report provided by [REDACTED] the diagnoses are 1. lumbar spine s/s syndrome, industrially related 2. lumbar facet arthropathy, industrially related 3. left knee below-knee amputation, 1996, with two revisions 4. left knee below-knee amputation, 1996, with two revisions 5. post-traumatic stress disorder 6. right rotator cuff tear, s/p arthroscopic repair on 5/1/09, industrially related 7. right knee internal derangement, s/p arthroscopic surgery times two, industrially related, with posterior cruciate ligament repair 8. temporomandibular joint dysfunction, industrially related 9. tinnitus with decreased hearing, industrially related 10. medication induced gastritis. Exam on 6/12/14 showed "tenderness to palpation along temporomandibular joints bilateral. The L-spine: palpable trigger points. Extension limited to 10 degrees. Facet loading causes pain in low back. C-spine: decreased range of motion on all planes. Right shoulder: abduction is 90 degrees. Bilateral elbow/wrists has positive Tinel's sign at right elbow/right wrist." [REDACTED] is requesting intrathecal morphine 1.5mg trial, magnetic resonance arthrogram of right shoulder, magnetic resonance arthrogram of right knee, and X-ray weight bearing right knee. The utilization review determination being challenged is dated 6/16/14 and denies intrathecal pump as patient has not exhausted conservative modalities, and denies the MR arthrograms of right shoulder and right knee due to lack of appropriate indications, and denies X-ray due to lack of red flags. [REDACTED] is the requesting provider, and he provided treatment reports from 12/9/13 to 7/10/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intrathecal Morphine 1.5mg trial.: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Intrathecal drug delivery systems, medications Page(s): 54-55.

Decision rationale: This patient presents with lower back pain, right knee pain, and right shoulder pain. The treater has asked for intrathecal morphine 1.5mg trial on 6/12/14. Psychological clearance for intrathecal infusion pump was provided by [REDACTED] on 3/3/14. Patient has failed conservative treatment, is requiring escalating doses of medication, and feels current medications are losing effectiveness per 6/12/14 report. Regarding Implantable drug-delivery systems (IDDSs), MTUS recommends only as an end-stage treatment alternative for selected patients for liver, colorectal, and head/neck cancers, severe spasticity for patient's who cannot tolerate oral Baclofen therapy, after failure of at least 6 months of less invasive methods, and following a successful temporary trial. Results of studies of opioids for musculoskeletal conditions (as opposed to cancer pain) generally recommend short use of opioids for severe cases, not to exceed 2 weeks, and do not support chronic use (for which a pump would be used), although IDDSs may be appropriate in selected cases of chronic, severe low back pain or failed back syndrome. Besides the failure of 6 months of other conservative treatment modalities, intractable pain secondary to a disease state with objective documentation of pathology, further surgical intervention is not indicated, psychological evaluation unequivocally states that the pain is not psychological in origin, and a temporary trial has been successful prior to permanent implantation as defined by a 50% reduction in pain. In this case, the patient has failed conservative treatment and medication usage is escalating. Requested Intrathecal Pump Trial for patient's severe chronic back pain appears to be consistent with MTUS guidelines. The request is medically necessary.

Magnetic Resonance (MR) Arthrogram of the Right Shoulder.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Shoulder, MR arthrogram.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Shoulder chapter MR Arthrogram Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. MRI is not as good for labral tears, and it may be necessary in individuals with persistent symptoms and findings of a labral tear that a MR arthrogram be performed even with negative MRI of the shoulder, since even with a normal MRI, a labral tear may be present in a small percentage of patients. Direct MR orthography can improve detection of labral

pathology. (Murray, 2009) If there is any question concerning the distinction between a full-thickness and partial-thickness tear, MR orthography is recommended. It is particularly helpful if the abnormal signal intensity extends from the undersurface of the tendon. (Steinbach, 2005) The main advantage of MR orthography in rotator cuff disease is better depiction of partial tears in the articular surface. (Hodler, 1992) It may be prudent to include an anesthetic in the solution in preparation for shoulder MR orthography. (Fox, 2012) See also Magnetic resonance imaging (MRI).

Decision rationale: This patient presents with lower back pain, right knee pain, and right shoulder pain and is s/p right rotator cuff tear, s/p arthroscopic repair from 2009. The treater has asked for magnetic resonance arthrogram of right shoulder on 6/12/14. Right shoulder MRI on 3/5/08 revealed a focal full-thickness tear of supraspinatus tendon at its insertion with mild acromioclavicular osteoarthritis and infraspinatus tendonitis. Regarding MR Arthrograms, ODG shoulder chapter states they are recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. In this case, patient has ongoing right shoulder pain, and the requested MR arthrogram of right shoulder to investigate potential re-tear of right rotator cuff seems reasonable and within ODG guidelines. The request is medically necessary.

Magnetic Resonance (MR) Arthrogram of Right Knee.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Knee and Leg, MR arthrography.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Knee Chapter MR Arthrography Recommended as a postoperative option to help diagnose a suspected residual or recurrent tear, for meniscal repair or for meniscal resection of more than 25%. In this study, for all patients who underwent meniscal repair, MR arthrography was required to diagnose a residual or recurrent tear. In patients with meniscal resection of more than 25% who did not have severe degenerative arthritis, avascular necrosis, chondral injuries, native joint fluid that extends into a meniscus, or a tear in a new area, MR arthrography was useful in the diagnosis of residual or recurrent tear. Patients with less than 25% meniscal resection did not need MR arthrography. (Magee, 2003).

Decision rationale: This patient presents with lower back pain, right knee pain, and right shoulder pain and is s/p right knee internal derangement, s/p arthroscopic surgery times two of unspecified dates. A right knee MRI performed on 3/5/08 was obscured by considerable magnetic susceptibility artifact. The treater has asked for MR arthrogram of right knee on 6/12/14. Regarding MR Arthrography, ODG knee chapter recommends as a postoperative option to help diagnose a suspected residual or recurrent tear, for meniscal repair or for meniscal resection of more than 25%. In this case, the patient is planning to undergo right knee arthroscopic surgery and a prior MRI was obscured. The requested MR Arthrogram of the right knee to help detect a potential tear appears reasonable and consistent with ODG guidelines. The request is medically necessary.

X-ray weight bearing right knee.: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 347.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

Decision rationale: This patient presents with lower back pain, right knee pain, and right shoulder pain. The treater has asked for X-ray weight bearing right knee on 6/12/14 "to help guide surgical planning." Review of the reports do not show any evidence of radiographs of the right knee being done in the past. Patient had redness along femoral condyle bilaterally, and had his existing socket trimmed to place the below-knee prosthetic in pressure tolerant areas such as patellar tendon bearing or popliteal fossa, but only provided temporary relief per 6/12/14. Regarding special studies for the knee, ACOEM states are not needed to evaluate most knee complaints until after a period of conservative care and observation. The clinical parameters for ordering knee radiographs following trauma in this population are: (1) Joint effusion within 24 hours of direct blow or fall, (2) Palpable tenderness over fibular head or patella, (3) Inability to walk (four steps) or bear weight immediately or within a week of the trauma and (4) Inability to flex knee to 90 degrees. Most knee problems improve quickly once any red-flag issues are ruled out. For patients with significant hemarthrosis and a history of acute trauma, radiography is indicated to evaluate for fracture. In this case, the treater has asked for X-ray weight bearing right knee to guide surgical planning which is reasonable. The request is medically necessary.