

Case Number:	CM14-0177539		
Date Assigned:	10/31/2014	Date of Injury:	09/26/2013
Decision Date:	12/08/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/27/2014

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 & 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 59 year-old male with an injury date on 09/26/2013. Based on the 09/24/2014 hand written progress report provided by [REDACTED], the diagnoses are: 1. L/s disc protrusion (A.T./NFN)2. Right hip S/S3, Left shoulder ACOA, bursitis4. Right knee effusion (swelled) 5. Right ankle Tenosyn of FHL6. Right foot/heel degenerative, According to this report, the patient complains of low back pain at 8/10, right hip pain at 8/10, right knee/foot/ankle pain at 5/10, and right heel pain at 3/10 with medications. With medication, low back pain at 6/10, right hip pain at 6/10, right knee/foot/ankle pain at 4/10, and right heel pain at 2/10. Sitting and repetitive motion would increase pain. Physical exam reveals positive straight leg raise and restricted range of motion of the left shoulder. The 08/22/2014 report indicates pain is controlled with medications and prolonged standing and bending would increase pain. There were no other significant findings noted on this report. The utilization review denied the request on 10/07/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 04/23/2014 to 11/22/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MR arthrogram left shoulder: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter under MR arthrogram

Decision rationale: According to the 09/24/2014 report by [REDACTED] this patient presents with low back pain at 6/10, right hip pain at 6/10, right knee/foot/ankle pain at 4/10, and right heel pain at 2/10 with medications. The treater is requesting MR arthrogram left shoulder. The utilization review denial letter states "there is not documentation of subjective findings (joint pain), shoulder x-ray nondiagnostic for etiology of pain, and failure of additional conservative treatment (OT/PT). Regarding MR Arthrogram, ODG guidelines state "Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair." Review of reports does not indicate that the patient had shoulder surgery to "suspected re-tear post-op rotator cuff repair" or to detect a labral tears. The treater does not mentions why a MR Arthrogram is need. The request is not medically necessary.

Flurbiprofen 20%, Cyclobenzaprine 4%, Lidocaine 5% cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: According to the 09/24/2014 report by [REDACTED] this patient presents with low back pain at 6/10, right hip pain at 6/10, right knee/foot/ankle pain at 4/10, and right heel pain at 2/10 with medications. The treater is requesting Flurbiprofen 20%, Cyclobenzaprine 4%, Lidocaine 5% cream. Regarding topical compounds, MTUS states that if one of the compounded product is not recommended then the entire compound is not recommended. In this case, Cyclobenzaprine is not recommended for topical formulation and Lidocaine is only allowed in a patch form and not allowed in cream, lotion or gel forms. The request is not medically necessary.

Aleveer Patch: Menthol 5%, Capsaicin 0.0375% #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: According to the 09/24/2014 report by [REDACTED] this patient presents with low back pain at 6/10, right hip pain at 6/10, right knee/foot/ankle pain at 4/10, and right heel pain at 2/10 with medications. The treater is requesting Aleveer Patch: Menthol 5%, Capsaicin 0.0375% #30. MTUS guidelines state "There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The request is not medically necessary.

Retro urinalysis: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: According to the 09/24/2014 report by [REDACTED] this patient presents with low back pain at 6/10, right hip pain at 6/10, right knee/foot/ankle pain at 4/10, and right heel pain at 2/10 with medications. The treater is requesting retro urinalysis. The utilization review denial letter states "there is no documentation of on-going opioid treatment." While MTUS Guidelines do not specifically address how frequent UDS should be obtained for various risks of opiate users, ODG Guidelines provide clearer recommendation. It recommends a once a year urine screen following initial screening within the first 6 months for management of chronic opiate use in a low risk patient. In this case, medical records indicate the patient has not had any recent UDS, and the patient is noted to be on Tramadol 150 mg, an opiate, since 04/23/2014. Therefore, an UDS would be reasonable. The request is medically necessary.

Cream as decided by pharmacist: Upheld

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 Page(s): 8.

Decision rationale: According to the 09/24/2014 report by [REDACTED] this patient presents with low back pain at 6/10, right hip pain at 6/10, right knee/foot/ankle pain at 4/10, and right heel pain at 2/10 with medications. The treater is requesting Cream as decided by pharmacist. In this case, treater does not specify the type of cream requested. It is the treater responsibility not the pharmacist to decided what the patient needs. MTUS page 8 requires that the treater provide monitoring of the patient's progress and make appropriate suggestions. The request is not medically necessary.