MAXIMUS Federal Services

Case Number:	CM14-0060550		
Date Assigned:	08/08/2014	Date of Injury:	11/12/2007
Decision Date:	09/12/2014	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	05/01/2014

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 Orthopedic Surgery 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:

45 year old female with an industrial injury dated 11/12/07. MRI of right shoulder dated 04/23/08 demonstrates a right shoulder rotator cuff syndrome status post arthroscopy, chromic cervical strain and rule out disc herniation. In additon patient had a shoulder arthroscopy on 07/14/08. MRI of 04/23/08 also shows evidence of lumbar spondylosis at L5-S1 with DDD moderate neuroforaminal narrowing, labral superior tear, tendinosis and chronic impingement. Exam note 03/07/14 states patient is status post multiple imaging studies and injections. The patient was noted to have 4/5 strenghth in the right upper extremity of C5-C7 with decresed sensation in the right as well. The right shoulder range of motion is 150/150/60 and left of 160/160/80. The patient has noted positive impingement. Claimant has a reported decrease in range of motion of the lumbar spine with 4/5 strength in the lower extremities and decresed sensation in L5 and S1 distribution.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI cervical spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: According to the CA MTUS/ACOEM Chapter 8, Neck and Upper Back Complaints pgs 177-178 regarding special studies (MRI)"For most patients presenting with true neck or upper back problems, specialstudies are not needed unless a three- or four-week period of conservativecare and observation fails to improve symptoms. Most patients improve quickly,provided any red-flag conditions are ruled out.Criteria for ordering imaging studies are:- Emergence of a red flag- Physiologic evidence of tissue insult or neurologic dysfunction- Failure to progress in a strengthening program intended to avoidsurgery- Clarification of the anatomy prior to an invasive procedure"In this case the patient does not meet any of the above criteria for an MRI of the cervical spine. The patient has no red flags to warrant advanced imaging from the exam notes from 3/7/14. Therefore the determination is for non-certification as not medically necessary.

MRI thoracic spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: CA MTUS/ACOEM Chapter 8, Neck and Upper Back Complaints, pgs 177-178 recommends MRI of the thoracic spine when there is a red flag, evidence of tissue insult or neurologic dysfunction. In this case the cited records do not demonstrate any of these conditions that would warrant an MRI of the thoracic spine. Therefore determination is for non-certification.

MRA right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder section, MR arthrogram.

Decision rationale: CA MTUS/ACOEM is silent on the issue of MR arthrogram. According to the ODG, Shoulder section, MR arthrogram is indicated for labral tears and suspected re-tear postoperatively following rotator cuff repair. Direct MR arthrography can improve detection of labral pathology. In this case the clinical notes from 3/7/14 does not demonstrate specific orthopedic exam findings concerning for labral pathology. In addition the MRI of the shoulder from 4/23/08 does not demonstrate a rotator cuff tear. Therefore the determination is for non-certification.

Ultram (Tramadol 50 mg) #90 Sig 1-2 tablets by mouth every 6-8 hours as needed for pain with no re-fill: 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): 93-94.

Decision rationale: With regards to Tramadol, per the CA MTUS, Tramadol "is a synthetic opioid affecting the central nervous system. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence of failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore use of Tramadol is not medically necessary.

Kera-Tek Gel 4 oz Apply a thin layer to affected area two-three times daily.: 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 topical analgesics Page(s): 111-112.

Decision rationale: Per the CA MTUS regarding topical analgesics, "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended."Therefore this request is not medically necessary.