

<b>Case Number:</b>	CM14-0072158		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	11/02/2006
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	04/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2014

### 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 Pain Management 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:

This is a female patient with the date of injury of November 2, 2006. A Utilization Review was performed on April 23, 2014 and recommended non-certification of X-rays cervical spine, MRI of the cervical spine, x-rays left shoulder, MR arthrogram left shoulder, refill Tramadol 50mg, per 4/1/14 report, refill Naproxen 550mg, per 4/1/14 report, and refill Tizanidine 4mg, per 4/1/14 report. A Comprehensive Orthopedic Evaluation dated April 1, 2014 identifies Subjective findings of neck pain and headaches at a level of 9/10, left shoulder pain at an 8-9/10, and tingling and numbness into the left hand and left lower forearm, which radiates into her four fingers, five through two. Physical Examination identifies cervical spine compression test is positive for pain. The dermatome test using a Wartenberg pinwheel test reveals C6-7 positive for analgesia or dysesthesia on the left upper extremity. Decreased cervical range of motion. There is a positive drop arm test on the left shoulder. Diagnoses identify AC cartilage disorder on the left shoulder, cervical radiculopathy, cervical sprain/strain, shoulder impingement syndrome on the left, subacromial bursitis on the left, and thoracic sprain/strain. Treatment Plan identifies MRI arthrogram and x-ray of the left shoulder, MRI of the cervical spine, cervical spine x-ray, Tramadol, Naproxen, and Tizanidine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Magnetic resonance imaging arthrogram of the left shoulder.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) OCCUPATIONAL MEDICINE PRACTICE Official Disability Guidelines (ODG), Shoulder Chapter, MR arthrogram.

**Decision rationale:** Regarding the request for magnetic resonance imaging arthrogram of the left shoulder, Occupational Medicine Practice Guidelines state that more specialized imaging studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines go on to recommend imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MR arthrogram as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. Within the documentation available for review, the patient is noted to have symptoms and findings consistent with impingement. However, there is no indication of a suspected labral tear or of a re-tear post-op rotator cuff repair. In the absence of such documentation, the currently requested magnetic resonance imaging arthrogram of the left shoulder is not medically necessary.

**X-ray of the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) OCCUPATIONAL MEDICINE PRACTICE Official Disability Guidelines (ODG) Shoulder, Radiography.

**Decision rationale:** Regarding the request for x-ray of the left shoulder, Occupational Medicine Practice Guidelines state that more specialized imaging studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines go on to recommend imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends radiography for acute shoulder trauma, rule out fracture or dislocation and acute shoulder trauma, questionable bursitis, blood calcium (Ca+)/approximately 3 months duration, first study. Within the documentation available for review, there is no indication of acute shoulder trauma. In the absence of such documentation, the currently requested x-ray of the left shoulder is not medically necessary.

**Magnetic resonance imaging of the cervical spine.: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 51-57.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Neck and Upper Back Complaints chapter, pages 176-177 Official Disability Guidelines (ODG), Neck Chapter, MRI.

**Decision rationale:** Regarding the request for cervical MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. Within the documentation available for review, there is documentation of neurologic deficit. However, there is no indication of failure of conservative treatment for at least 3 months. In the absence of such documentation the requested cervical MRI is not-medically necessary.

**Seven views x-ray of the cervical spine.: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 51-57.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004 OCCUPATIONAL MEDICINE PRACTICE GUIDELINES, Neck and Upper Back Complaints Chapter, pages 177-178 Official Disability Guidelines (ODG), Neck & Upper Back Chapter, Radiography.

**Decision rationale:** Regarding request for cervical spine x-ray, Occupational Medicine Practice Guidelines state that x-rays should not be recommended in patients with neck pain in the absence of red flags for serious spinal pathology even if the pain has persisted for at least 6 weeks. However, it may be appropriate when the physician believes it would aid in patient management. Guidelines go on to state that subsequent imaging should be based on new symptoms or a change in current symptoms. Within the documentation available for review, there is no documentation of red flags. Additionally, the requesting physician has not stated how his medical decision-making will be changed based upon the outcome of the currently requested cervical x-ray. In the absence of clarity regarding those issues, the currently requested cervical x-ray is not medically necessary.

**Tramadol 50mg, #60 with two refills.: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing page 43: Chronic Pain Medical Treatment Guidelines page 80-81, 91 and 93-94; Opioids for Chronic Pain Tramadol.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-79.

**Decision rationale:** Regarding the request for Ultram, California Pain Medical Treatment Guidelines state that Ultram is a short acting opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the Ultram is improving the patient's function (in terms of specific objective functional improvement) or pain (in terms of reduced NRS, or percent reduction in pain), no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested Ultram is not medically necessary.

**Naproxen 550mg, # 60 with two refills.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-steroidal anti-inflammatory drugs) Naproxen (Naprosyn) Page(s): 67 and 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** Regarding the request for Naproxen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naproxen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Naproxen is not medically necessary.

**Tizanidine 4mg, #30 with two refills.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodic Drugs Tizanidine (Zanaflex) Page(s): 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** Regarding the request for Tizanidine, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Tizanidine specifically has been shown to be beneficial in the treatment of myofascial pain and as an adjunct to treat fibromyalgia. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6

months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Tizanidine. Additionally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested Tizanidine is not medically necessary.