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| Case Number: | CM14-0207152 | | |
| Date Assigned: | 12/19/2014 | Date of Injury: | 05/04/2010 |
| Decision Date: | 02/13/2015 | UR Denial Date: | 11/12/2014 |
| Priority: | Standard | Application Received: | 12/10/2014 |

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 Rehab, 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 38 year old female with an injury date of 05/04/10. The patient is also status post left shoulder arthroscopic subacromial decompression, left shoulder arthroscopic extensive debridement of partial rotator cuff tear, left shoulder open Mumford type distal clavicle resection, as per operative report dated 01/13/14. The patient is status post left sacroiliac joint fusion performed on 01/14/13, as per progress report dated 08/11/14. Based on the progress report dated 10/31/14, the patient complains of pain in lower back, upper back, left hip, neck, and left shoulder. Physical examination reveals pain and tenderness in the cervical spine at C1-C6, pain in thoracic spine at T1/T8, and pain in lumbar spine from L1-L4. There is swelling in the affected areas as well. Range of motion of the cervical spine and bilateral shoulders is limited. In progress report dated 07/16/14, the patient rates the pain as 3/10 on a good day to 10/10 on a bad day. As per progress report dated 10/02/14, which was reviewed in progress report dated 10/31/14, the patient has neck pain, headache and stiffness. She also has swelling, tingling, numbness, weakness and burning dysesthesias in the left upper extremity. She was diagnosed with systemic lupus which is currently under control. The patient has received conservative treatments such as nerve block injection, chiropractic therapy, narcotic pain medications, physical therapy, TENS unit, and Acupuncture, as per progress report dated 07/16/14. The patient also underwent left stellate ganglion block under fluoroscopy on 07/11/14, as per the operative report. Medications include Oxycodone, Estradiol, Zolpidem, Azathioprine, Clonazepam, Progesterone, Ergocalciferol, Hydroxycloquine, Pentoxifylline, Amitriptyline, Fluoxetine, Temazepam, and Ondansetron, as per report dated 07/17/14. The patient is to remain off work until 01/01/15, as per progress report dated 10/31/14. Diagnoses, 10/31/14:- Slip and fall accident - Sprain/strain of lumbar spine- Sprain/strain of thoracic spine- Sprain/strain of cervical spine- Sprain/strain left spine- Sprain/strain left shoulder- Contusion left hip- Muscle spasms-

Myalgia/myositisThe treating physician is requesting for (a) MRI /MRA / MRV OF BOTH UPPER EXTREMITIES AND THROAX (b) BACK BUOY PADDED CHAIR (c) SIX PHYSICAL THERAPY SESSION IF REST ORTHOSIS IS APPROVED (d) PRODIN AND/OR RIZATRIPTAN OR OTHER APPROPRIATE TRIPTANS FOR TOS INDUCED MIGRAINE. The utilization review determination being challenged is dated 11/12/14. Treatment reports were provided from 03/11/14 - 11/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI/MRA/MRV of both upper extremities and Thorax: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic Resonance Imaging (MRI), MR Arthrogram; <http://www.ncbi.nlm.nih.gov/pubmed/22920352>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic) chapter, MRI's (magnetic resonance imaging).

Decision rationale: The patient presents with pain in lower back, upper back, left hip, neck, and left shoulder, as per progress report dated 10/31/14. The request is for MRI /MRA / MRV OF BOTH UPPER EXTREMITIES AND THROAX. The patient is also status post left shoulder arthroscopic subacromial decompression, left shoulder arthroscopic extensive debridement of partial rotator cuff tear, left shoulder open Mumford type distal clavicle resection, as per operative report dated 01/13/14. The patient is status post left sacroiliac joint fusion performed on 01/14/13, as per progress report dated 08/11/14. ODG Guidelines, Forearm, Wrist, & Hand (Acute & Chronic) chapter, MRI's (magnetic resonance imaging) Magnetic resonance imaging has been advocated for patients with chronic wrist pain because it enables clinicians to perform a global examination of the osseous and soft tissue structures. It may be diagnostic in patients with triangular fibrocartilage (TFC) and intraosseous ligament tears, occult fractures, avascular neurosis, and miscellaneous other abnormalities. - Chronic wrist pain, plain films normal, suspect soft tissue tumor- Chronic wrist pain, plain film normal or equivocal, suspect Kienbck's disease- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008). Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In progress report dated 10/02/14, which was reviewed in progress report dated 10/31/14, the patient complains of swelling, tingling, numbness, weakness and burning dysesthesias in the left shoulder, arm and hand. There is limited strength with no grip. "The arm seems dead to her," the report says. The patient also finds it difficult to turn her neck. Progress report dated 07/16/14 states that the patient has had prior MRI but does not specify the date or the body part. As per progress report dated 05/07/14, the patient underwent an MRI of the left shoulder on 08/15/12 (prior to left shoulder surgery) which revealed partial thickness undersurface tear of the infraspinatus as well as subdeltoid bursitis. No other MRI reports are available for review. In progress report dated 10/02/14, the treating

physician requests for MRI/ MRV / MRA of both upper extremities and thorax but does not specify the reason. While the patient does have symptoms in the left upper extremity, an MRI of the right side appears unreasonable as there are no symptoms or red flags in the right side and the patient is not post-op. Hence, the request IS NOT medically necessary.

Back Buoy Padded Chair: 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) Knee and Leg Chapter, Durable Medical Equipment (DME)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Knee & Leg, DME; and on the Non-MTUS Other Medical Treatment Guideline or Medical Evidence: <http://www.blaisdells.com/wp-content/uploads/2013/04/NEW-ERGO-CATALOG2.pdf>. Aetna Clinical Policy Bulletin: Pressure Reducing Support Surfaces, Number: 0430.

Decision rationale: The patient presents with pain in lower back, upper back, left hip, neck, and left shoulder, as per progress report dated 10/31/14. The request is for BACK BUOY PADDED CHAIR. The patient is also status post left shoulder arthroscopic subacromial decompression, left shoulder arthroscopic extensive debridement of partial rotator cuff tear, left shoulder open Mumford type distal clavicle resection, as per operative report dated 01/13/14. The patient is status post left sacroiliac joint fusion performed on 01/14/13, as per progress report dated 08/11/14. "Back Buoy reduces pressure or irritation of the nerves, veins, and lymphatics supplying the upper extremities. Back Buoy relieves or reduces the mechanical contribution to this abnormal compression that is produced by postural weakness of all kinds," according to <http://www.blaisdells.com/wp-content/uploads/2013/04/NEW-ERGO-CATALOG2.pdf>. Aetna considers pressure-relieving support surfaces medically necessary as durable medical equipment (DME) according to the selection criteria set forth below, as per Aetna Clinical Policy Bulletin: Pressure Reducing Support Surfaces, Number: 0430. ODG guidelines, Chapter Knee & Leg and Title DME, states that "The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. (CMS, 2005)" DME is "Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below." In progress report dated 10/02/14, which is reviewed in progress report dated 10/31/14, the treating physician recommends the Back Buoy "for correction of TOS while seated and not wearing the vest..." The treating physician states further that the "This is solid, rigid, scapulothoracic orthosis that fits in any chair or vehicle, shown to adduct and elevate both scapulae while sitting. This adjustment increases the diameter of the superior thoracic aperture with widening of the costo-clavicular interval." The treating physician states that independent ultrasound studies have shown improvement in venous return in the vertebral, subclavian and brachiocephalic veins. The treating physician expects the patient's back symptoms to improve with this device and says that "most patients are able to reduce medications." The treating physician also states that this equipment will pay for itself in a month due to reduction in drug therapy and side effects, and

"will last a lifetime." Aetna supports the use of pressure reducing support surfaces and classifies them as DME. The Back Buoy also fits the criteria for DME as per ODG. Hence, this request IS medically necessary.

Six physical therapy sessions, if vest orthosis is approved: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The patient presents with pain in lower back, upper back, left hip, neck, and left shoulder, as per progress report dated 10/31/14. The request is for SIX PHYSICAL THERAPY SESSION IF REST ORTHOSIS IS APPROVED. The patient is also status post left shoulder arthroscopic subacromial decompression, left shoulder arthroscopic extensive debridement of partial rotator cuff tear, left shoulder open Mumford type distal clavicle resection, as per operative report dated 01/13/14. The patient is status post left sacroiliac joint fusion performed on 01/14/13, as per progress report dated 08/11/14. MTUS Guidelines pages 98 to 99 state that for patients with "myalgia and myositis, 9 to 10 sessions over 8 weeks are allowed, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits over 4 weeks are allowed." A review of the available progress reports does not discuss prior physical therapy. However, given the patient's date of injury, it is reasonable to assume that she has received some therapy sessions at least. In progress report dated 10/02/14, reviewed in progress report dated 10/31/14, the treating physician states that "If she is granted vest orthosis then she should have six P.T. Sessions..." The purpose is to "give her the best long term outcome combining orthotics with home exercise and correct medications." Assuming that the patient has not received recent physical therapy, the treating physician's request for six sessions appears reasonable. However, the UR letter states that the patient's vest orthosis has not been authorized. Hence, the request for physical therapy IS NOT medically necessary.

Prodrin and/or Rizatriptan or other appropriate Triptans for TOS induced migraine:
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) Triptans

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chapter 'Head' and topic 'Triptan'.

Decision rationale: The patient presents with pain in lower back, upper back, left hip, neck, and left shoulder, as per progress report dated 10/31/14. The request is for PRODIN AND/OR RIZATRIPTAN OR OTHER APPROPRIATE TRIPTANS FOR TOS INDUCED MIGRAINE. The patient is also status post left shoulder arthroscopic subacromial decompression, left

shoulder arthroscopic extensive debridement of partial rotator cuff tear, left shoulder open Mumford type distal clavicle resection, as per operative report dated 01/13/14. The patient is status post left sacroiliac joint fusion performed on 01/14/13, as per progress report dated 08/11/14. ODG Guidelines, chapter 'Head' and topic 'Triptan', state that Triptans are "Recommended for migraine sufferers. At marketed doses, all oral triptans (e.g., sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. A poor response to one triptan does not predict a poor response to other agents in that class." In progress report dated 10/02/14, which was reviewed in progress report dated 10/31/14, the treating physician states that the patient has migraine syndrome due to the accident. He says that the "headaches start in left suboccipital area." The patient is taking Topamax which is helping but is insufficient. The treating physician believes that increasing the dose of Topamax can lead to unwanted sedation and cognitive impairment. "She should have trials of Prodrin, a non-sedating vasoconstrictor known to be very helpful in the control of migraine (now generic) and /or rizatriptan or other appropriate triptans for immediate control of headache." ODG guidelines also support the use of Triptans for migraine headaches. A trial of this class of medication appears reasonable and supported by the guidelines. Hence, this request IS medically necessary.