

Case Number:	CM15-0008338		
Date Assigned:	01/23/2015	Date of Injury:	02/02/2011
Decision Date:	03/24/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	01/14/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker (IW) is a 48 year old male, who sustained an industrial injury on February 2, 2011. He has reported left shoulder pain, left thumb pain, right elbow pain, right forearm pain and right thumb pain and was diagnosed with bilateral upper condyle inflammatory problems with both shoulders possible carpal tunnel syndrome. Treatment to date has included radiographic imaging, diagnostic studies, pain medications, lifestyle modifications, right rotator cuff repair subacromial decompression distal clavicle excision, physical therapy, acupuncture therapy and steroid injections. Currently, the IW complains of left shoulder pain, left thumb pain, right elbow pain, right forearm pain and right thumb pain. The IW reported an industrial injury in 2011. Since the injury, he has developed continued shoulder and elbow pain. On July 9, 2014, the pain continued. It was noted he failed several conservative therapies. Neurodiagnostic studies on July 10, 2013, of the upper extremities revealed no abnormalities. Nerve conduction studies were consistent with right carpal tunnel syndrome. On August 12, 2014, radiographic imaging of the right shoulder revealed no acute fracture and mild diastasis of the acromioclavicular joint. The pain continued and the IW continued to go to follow up appointments. Pain medications were ordered and adjusted. It was noted a request for a follow up appointment was made only two weeks after his last exam. It was noted the IW had a prescription covering 30 days, for pain medications. On January 9, 2015, Utilization Review non-certified a request for a follow up visit on December 22, 2014, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On January 13, 2015, the injured worker submitted an application for IMR for review of requested follow up visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Follow up visit scheduled 12/22/14: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM for Independent Medical Examinations and Consultations regarding Referrals Chapter 7

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): Chapter 7- Independent Medical Examinations and Consultations, page 127.

Decision rationale: Guidelines state office visits and follow-ups are determined to be medically necessary and play a critical role in the proper diagnosis and treatment based on the patient's concerns, signs and symptoms, clinical stability along with monitoring of medications including opiates. Determination of necessity requires individualized case review and assessment with focus on return to function of the injured worker. Submitted reports have adequately demonstrated continued symptoms and findings to allow for follow-up intervention and care from the provider as indicated to achieve eventual independence from medical utilization and a follow-up visit is reasonable. The Retro Follow up visit scheduled 12/22/14 is medically necessary and appropriate.

Retro Advanced DNA Medicated Kit #1, done 12/08/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cytokine DNA Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines DNA Testing for Pain, page 42.

Decision rationale: There was no mention of indication or specifics for justification of DNA testing. It is unclear what type of DNA testing is being requested. Submitted reports have not adequately demonstrated clear indication, co-morbid risk factors, or extenuating circumstances to support for non-evidence-based diagnostic DNA testing outside guidelines criteria. Per Guidelines, Cytokine DNA testing is not recommended as scientific evidence is insufficient to support its use in the diagnosis of chronic pain. The Retro Advanced DNA Medicated Kit #1, done 12/08/14 is not medically necessary and appropriate.

Retro Urine drug screen Kit 12/8/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing, page 43.

Decision rationale: Per MTUS Guidelines, urine drug screening is recommended as an option before a therapeutic trial of opioids and for on-going management to differentiate issues of abuse, addiction, misuse, or poor pain control; none of which apply to this patient who has been prescribed long-term opioid this chronic injury. Presented medical reports from the provider have unchanged chronic severe pain symptoms with unchanged clinical findings of restricted range and tenderness without acute new deficits or red-flag condition changes. Treatment plan remains unchanged with continued medication refills without change in dosing or prescription for chronic pain. There is no report of aberrant behaviors, illicit drug use, and report of acute injury or change in clinical findings or risk factors to support frequent UDS. Documented abuse, misuse, poor pain control, history of unexpected positive results for a non-prescribed scheduled drug or illicit drug or history of negative results for prescribed medications may warrant UDS and place the patient in a higher risk level; however, none are provided. The Retro Urine drug screen Kit 12/8/14 is not medically necessary and appropriate.

Retro Omeprazole 20mg #60 12/8/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risks.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular risk, Pages 68-69.

Decision rationale: Prilosec (Omeprazole) medication is for treatment of the problems associated with erosive esophagitis from GERD, or in patients with hypersecretion diseases. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Omeprazole (Prilosec) namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any history, symptoms, or GI diagnosis to warrant this medication. The Retro Omeprazole 20mg #60 12/8/14 is not medically necessary and appropriate.

Retro Tramadol HCL 37.5/325mg #60 12/8/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) 74-96.

Decision rationale: Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant

therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury without acute flare, new injury, or progressive deterioration. The Retro Tramadol HCL 37.5/325mg #60 12/8/14 is not medically necessary and appropriate.

Neuro consult for the Right shoulder, arm, and elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): Chapter 7- Independent Medical Examinations and Consultations, page 127.

Decision rationale: Submitted reports have not demonstrated any clear or specific indication or diagnoses indicative of a neurology consultation for uncomplicated complaints of headaches. There are no identifying diagnoses or clinical findings to support for specialty care beyond the primary provider's specialty nor is there any failed treatment trials rendered for any unusual or complex pathology that may require second opinion. Submitted reports have not demonstrated clear specific change in clinical findings or deterioration of neurological deficits to support for neurology consult with ongoing diagnostic requests pending. The Neuro consult for the Right shoulder, arm, and elbow is not medically necessary and appropriate.

EMG/NCV right upper extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Chapter 8 Neck & Upper Back, Special Studies and Diagnostic and Treatment Considerations, pages 177-178.

Decision rationale: The patient has established diagnosis of CTS by previous EMG/NCV and continues to treat without functional change. Additionally, current submitted reports have not adequately demonstrated any change in chronic symptoms and clinical findings of neurological deficits suggestive of deterioration. There are also no identified new injuries, acute flare-up or red-flag conditions with changed chronic symptoms and clinical findings to support repeating the electrodiagnostic study. The EMG/NCV right upper extremity is not medically necessary and appropriate.