

Case Number:	CM15-0057792		
Date Assigned:	04/02/2015	Date of Injury:	08/29/2011
Decision Date:	05/08/2015	UR Denial Date:	03/09/2015
Priority:	Standard	Application Received:	03/26/2015

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 is a 56 year old, male who sustained a work related injury on 8/29/11. The diagnoses have included a radius fracture, left elbow surgery, cervical intervertebral disc disorder with myelopathy, rotator cuff syndrome and left shoulder surgery. Treatments have included topical medicated cream, medications and rest. In the Treating Physician's Comprehensive Pain Management Consultation and Report dated 3/5/15, the injured worker complains of cervical and bilateral arm pain. He complains of pain in all joints in both arms including both shoulders. He rates the pain an 8/10. He has palpable tenderness at cervical spine and both shoulders. The treatment plan is the request for an MRI of the cervical spine, for a refill of medicated cream and for a home interferential stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the cervical spine, lumbar spine, and right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 177-178, 207-208. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back (Acute & Chronic) chapter, Magnetic resonance imaging (MRI) Shoulder chapter, MRI.

Decision rationale: The 56 year old patient complains of pain in the cervical spine, lumbar spine, left upper extremity, left knee, and right anterior shoulder along with headaches, as per progress report dated 03/05/15. The request is for MRI OF THE CERVICAL SPINE, LUMBAR SPINE, AND RIGHT SHOULDER. There is no RFA for the case, and the patient's date of injury is 08/29/11. The patient is also experiencing numbness in left lower extremity and bilateral hands 80% of the time along with anxiety, stress and insomnia, as per progress report dated 03/05/15. Diagnoses included cervical intervertebral disc disorder, lumbar intervertebral disc disorder, shoulder rotator cuff syndrome, and radial fracture. The patient is status post arthroscopic shoulder surgery, and status post reconstruction of left elbow and left humerus. The patient is temporarily totally disabled, as per the same progress report. ACOEM Guidelines, chapter 8, page 177 and 178, state unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. ODG Guidelines do not support MRIs unless there are neurologic signs/symptoms present. Repeat MRI's are indicated only if there has been progression of neurologic deficit. ACOEM Guidelines, chapter 8, page 177 and 178, state Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. ODG Guidelines, chapter 'Neck and Upper Back (Acute & Chronic)' and topic 'Magnetic resonance imaging (MRI)', have the following criteria for cervical MRI: (1) Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present; (2) Neck pain with radiculopathy if severe or progressive neurologic deficit; (3) Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; (4) Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present; (5) Chronic neck pain, radiographs show bone or disc margin destruction; (6) Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"; (7) Known cervical spine trauma: equivocal or positive plain films with neurological deficit; (8) Upper back/thoracic spine trauma with neurological deficit. ACOEM Guidelines has the following regarding shoulder MRI on pages 207-208, routine testing (laboratory test, plain film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first 6 weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raise a suspicion of a serious shoulder condition or referred pain. ACOEM Guidelines page 207-208 continue to state that the primary criteria for ordering imaging studies include: 1.) emergence of red flags; 2.) physiologic evidence of tissue insult; 3.) failure to progress in strengthening program; and 4) clarification of anatomy prior to an invasive procedure. ODG Guidelines under shoulder chapter supports MRI of the shoulder if conservative measures have failed and rotator cuff/labral tear are suspected. In this case, the patient has undergone MRI of the cervical spine on 02/14/13 and 10/26/11, MRI of the lumbar spine on 10/26/11, and MRI of the right shoulder on 02/15/13, as per progress report dated 11/11/14. In progress report dated 03/05/15, the treating physician is requesting for updated MRI studies. The physician, however, does not explain the purpose of the request. Additionally, there are no red flags and the patient does not present with a new injury to warrant a new set of MRI's. Hence, the request IS NOT medically necessary.

FCL Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.0375%, Hyaluronic acid 0.20% 180 gms: Upheld

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

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

Decision rationale: The 56 year old patient complains of pain in the cervical spine, lumbar spine, left upper extremity, left knee, and right anterior shoulder along with headaches, as per progress report dated 03/05/15. The request is for FCL FLURBIPROFEN 20%, BACLOFEN 2%, DEXAMTHASONE 2%, MENTHOL 2%, CAMPHOR 2%, CAPSAICIN 0.0325%, HYALURONIC ACID 0.20% 180 gms. There is no RFA for the case, and the patient's date of injury is 08/29/11. The patient is also experiencing numbness in left lower extremity and bilateral hands 80% of the time along with anxiety, stress and insomnia, as per progress report dated 03/05/15. Diagnoses included cervical intervertebral disc disorder, lumbar intervertebral disc disorder, shoulder rotator cuff syndrome, and radial fracture. The patient is status post arthroscopic shoulder surgery, and status post reconstruction of left elbow and left humerus. The patient is temporarily totally disabled, as per the same progress report. The MTUS guidelines, page 111, do not support the use of topical NSAIDs such as Flurbiprofen for axial, spinal pain, but supports its use for peripheral joint arthritis and tendinitis. As for Capsaicin, MTUS guidelines state that they are recommended only as an option in patients who have not responded or are intolerant to other treatments. The MTUS guidelines page 111 on topical analgesics states that it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS further states, any compounded product that contains at least one drug, or drug class, that is not recommended is not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product."In this case, the prescription for topical compound is noted in progress report dated 03/05/15. The treating physician states that this topical formulation would help reduce pain, increase function and mobility and decrease the need of additional area medications. The MTUS guidelines do not support any muscle relaxants as a topical product and Baclofen is included in this compounded topical medication. The current request IS NOT medically necessary.

Rental of interferential stimulator home unit for initial trial for 60 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The 56 year old patient complains of pain in the cervical spine, lumbar spine, left upper extremity, left knee, and right anterior shoulder along with headaches, as per progress report dated 03/05/15. The request is for RENTAL OF INTERFERENTIAL STIMULATOR HOME UNIT FOR INITIAL TRIAL FOR 60 DAYS. There is no RFA for the case, and the patient's date of injury is 08/29/11. The patient is also experiencing numbness in left lower extremity and bilateral hands 80% of the time along with anxiety, stress and insomnia, as per progress report dated 03/05/15. Diagnoses included cervical intervertebral disc disorder, lumbar intervertebral disc disorder, shoulder rotator cuff syndrome, and radial fracture. The patient is status post arthroscopic shoulder surgery, and status post reconstruction of left elbow and left humerus. The patient is temporarily totally disabled, as per the same progress report. For Interferential Current Stimulation (ICS), MTUS guidelines, page 118-120, state, that not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.) If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. In this case, the treating physician is requesting for a 60 day rental of the IF unit as the patient has been suffering from chronic pain for over 90 days, as per progress report dated 03/05/15. However, in the same report, the physician states that the patient feels better with topical compound, pain medication and rest. There is no documentation of significant post-operative pain. Additionally, MTUS only allows for a one-month trial. Hence, the request IS NOT medically necessary.