

Case Number:	CM14-0210901		
Date Assigned:	12/23/2014	Date of Injury:	10/05/2012
Decision Date:	02/27/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/16/2014

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. 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 & Rehabn, Pain Management

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 patient with a date of injury of 10/5/12. A utilization review determination dated 11/26/14 recommends non-certification/modification of physiatry consult, cervical traction with air bladder, right shoulder fluoroscopy evaluation and x-ray, and Norco. 10/23/14 medical report identifies bilateral wrist pain, spasms in the left arm, numbness and tingling in all fingertips, issue with gripping and grasping with incidents of dropping items, unable to form a complete fist, Norco and tramadol ER decrease pain and allow her to be functional. Right shoulder MRI is said to show possible calcific tendinitis, mild AC joint wear, and tendinopathy along the biceps tendon. On exam, there is bilateral limited wrist ROM and edema. Recommendations include neck traction with air bladder and hot/cold wrap, carpal tunnel release of the left wrist, left shoulder arthroscopic surgery with pre-op items, Norco, Voltaren gel, physiatry consultation (for persistent pain in both wrists), and right shoulder fluoroscopic evaluation and x-ray.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Physiatry consult: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254.

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, Independent Medical Examinations and Consultations Chapter, Page 127 Chapter 7

Decision rationale: Regarding the request for consultation, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, the provider recommends the consultation due to persistent wrist pain, but there is no clear indication for this consultation given that the provider has also concurrently recommended wrist surgery. In the absence of clarity regarding the above issues, the currently requested consultation is not medically necessary.

Cervical traction with air bladder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, Traction

Decision rationale: Regarding the request for cervical traction, Occupational Medicine Practice Guidelines state that there is no high-grade scientific evidence to support the use of traction. They go on to state the traction is not recommended. ODG states that home cervical traction is recommended for patients with radicular symptoms, in conjunction with a home exercise program. Within the documentation available for review, there is no indication of current radicular symptoms and adherence to home exercise. In the absence of clarity regarding those issues, the currently requested cervical traction is not medically necessary.

Right shoulder fluoroscopy evaluation & x-ray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Radiography

Decision rationale: Regarding the request for right shoulder fluoroscopy evaluation and x-ray, CA MTUS and ACOEM note that routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on

history or examination raises suspicion of a serious shoulder condition or referred pain. Cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Red flags include evidence of fractures, dislocation, infection, tumor, progressive neurologic and/or vascular compromise, cardiac condition, subdiaphragmatic conditions, and acute rotator cuff tear in a young worker. Within the documentation available for review, MRI has apparently been done previously with positive findings and there are no subsequent red flags or another clear indication for following up an MRI with fluoroscopy and x-ray. No clear rationale is provided identifying the medical necessity of the request. In the absence of clarity regarding the above issues, the currently requested right shoulder fluoroscopy evaluation and x-ray is not medically necessary.

90 Norco 10/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Norco, California Pain Medical Treatment Guidelines note that it is an 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 medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco is not medically necessary.