

Case Number:	CM14-0213649		
Date Assigned:	12/31/2014	Date of Injury:	05/12/2014
Decision Date:	02/27/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	12/22/2014

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

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 54 year old male with an injury date of 05/12/14. Based on the progress report dated 11/20/14 provided by treating physician, the patient complains of pain to the neck, mid back, low back, left shoulder, bilateral knees, and headaches following a concussion. Patient is status post two steroid injections to the posterior shoulder, reporting temporary relief. Physical examination 11/20/14 revealed tenderness to palpation to the left shoulder, rotator cuff, and biceps tendon, positive impingement and Hawkin's signs noted. No findings pertinent to head, back, or knee complaints were included with the examination. The patient is currently prescribed Norco, Gabapentin, Flexeril, Lidopro and Protonix. Diagnostic imaging included cervical MRI dated 08/16/14 significant findings include: "Straightening to reversal of the cervical vertebral body, consistent with musculoskeletal strain. Narrowing of the ventral subarachnoid space C3-C6. Foraminal narrowing seen at multiple levels..." Lumbar MRI dated 07/11/14 significant findings include: "Mild disc desiccation noted throughout the lumbar spine, L1-2 2mm circumferential disc bulge producing mild foraminal stenosis, L2-3 1-2mm posterior annular bulge and mild foraminal stenosis, L3-4 2mm circumferential disc bulge producing mild foraminal stenosis, small amount of fluid in the facet joints." Echo left knee dated 06/12/14 significant findings include: "Mild lateral subluxation of the patella mild bone spurring noted in all compartments areas of erosion and thinning of cartilage in all compartments severe abnormal signal throughout the medial meniscus large complex tear of the anterior and posterior horns involving femoral and tibial surfaces anterior cruciate ligament is intact with an elongated cyst in the center of the ligament." Echo left shoulder dated 06/12/14 significant

findings include: "Severe glenohumeral joint arthritis... severe subchondral cystic change in the posterior half the glenoid from the apex to the inferior border degeneration of the biceps tendon and superior labral complex with tear of the labrum extending posteriorly, Mild infraspinatus, supraspinatus, and subscapularis tendinosis moderate to severe hypertrophic acromioclavicular joint arthrosis." Patient is currently not working. Diagnosis 11/20/14 [sic], Discogenic cervical condition with MRI showing bulging at C4-C6 as well as bulging at C6-C7. He does have some radiculopathy indeed. He does have episodes of headaches which are related to concussion for which MRI is not available, Post-concussion syndrome, Discogenic thoracic condition with MRI showing disc disease at T9-T10 with vertebral hypertrophy at T6-T7, Discogenic lumbar condition noted with facet changes at L3-L4, L5-S1 and disc at L3-L4 and mostly at L4-L5 and L5-S1. Nerve studies were being denied. Impingement syndrome of shoulder on the left with bicipital tendinitis. MRI showing labral tear, partial rotator cuff tear, arthritis along the joint line and biceps tendon involvement, Internal derangement of the knee on the left with MRI showing meniscus tear and arthritis along the joint line. Chronic pain syndrome the utilization review determination being challenged is dated 12/17/14. The rationale follows: 1) Referral for pain management cervical ESI, psychiatry consult for delayed recovery: "There is no evidence of active radiculopathy there are no reports of neurological status of upper or lower extremities, no findings of positive dural tension tests and diagnostic imaging findings that demonstrate nerve root compression. Regarding psychiatric referral, there is no evidence the patient has been evaluated for risk for delayed recovery..." 2) Topamax: "The patient has reduced neuropathic pain taking Gabapentin. There is no indication for taking two anti-epilepsy drugs." Treatment reports were provided from 05/15/14 to 11/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 referral to [REDACTED] for pain management, psychiatry for possible injection for neck and low back and psychiatry: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

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) ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, Independent Medical Examination and Consultations, page 127

Decision rationale: The patient presents with pain to the neck, mid back, low back, left shoulder, bilateral knees, and headaches following a concussion. Patient is status post two steroid injections to the posterior shoulder, reporting temporary relief. The request is for 1 referral to [REDACTED] for pain management, psychiatry for possible injection for neck and low back and psychiatry. Physical examination 11/20/14 revealed tenderness to palpation to the left shoulder, rotator cuff, and biceps tendon, positive impingement and Hawkin's signs noted. No findings pertinent to head, back, or knee complaints were included with the examination. The patient is currently prescribed Norco, Gabapentin, Flexeril, Lidopro and Protonix. Diagnostic imaging included cervical MRI dated 08/16/14, lumbar MRI dated 07/11/14, echo left knee and shoulder

dated 06/12/14. Patient is not currently working. ACOEM Chapter 7 was not adopted into the MTUS guidelines, but would be the next highest review standard, as MTUS does not discuss consultations. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, Independent Medical Examination and Consultations, page 127 states: "The occupational health practitioner may refer to other specialists 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." In regards to the pain referral, the request, as written, is not a request for injections, but a request for consultation with the physician that will presumably evaluate the patient and determine need for injections. The treater did not provide enough information to determine if the patient meets the MTUS or ODG criteria for lumbar or cervical injections, namely the presence of radiculopathy in the upper or lower extremities. It appears, however, that this patient suffers from a multitude of poorly controlled discogenic and musculoskeletal complaints, so conferring with a pain specialist might produce appreciable benefits. Therefore, the request for pain management consultation IS medically necessary. In regards to the request for psychiatric consult, the treater has failed to adequately document any delayed healing risk factors which would generally indicate a need for such a referral. However, this patient's diagnosis of chronic pain syndrome establishes that a psychiatric consult for the purposes of improving pain outcomes could be a possible treatment avenue, and the treater is reasonably justified in seeking a specialist opinion on the matter. Therefore, the request is medically necessary.

Topamax 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate (Topamax) Page(s): 21.

Decision rationale: The patient presents with pain to the neck, mid back, low back, left shoulder, bilateral knees, and headaches following a concussion. Patient is status post two steroid injections to the posterior shoulder, reporting temporary relief. The request is for Topamax 50MG #60. Physical examination 11/20/14 revealed tenderness to palpation to the left shoulder, rotator cuff, and biceps tendon, positive impingement and Hawkin's signs noted. No findings pertinent to head, back, or knee complaints were included with the examination. The patient is currently prescribed Norco, Gabapentin, Flexeril, LidoPro and Protonix. Diagnostic imaging included cervical MRI dated 08/16/14, lumbar MRI dated 07/11/14, echo left knee and shoulder dated 06/12/14. Patient is not currently working. Regarding Topiramate (Topamax), MTUS Guidelines page 21 states "Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants have failed." MTUS Guidelines page 16 and 17 regarding antiepileptic drugs for chronic pain also states "that there is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs, and mechanisms. Most randomized controlled trials for the use of this class of medication for neuropathic pain had been directed at postherpetic neuralgia and painful polyneuropathy." Treater has not provided a reason for the request. Review of the reports provided establish that the patient has obtained some relief from utilizing oral Gabapentin for

pain which keeps him awake at night. The records provided have not documented a rationale for the concurrent utilization of both Topamax and Gabapentin. Therefore, this request is not medically necessary.