

Case Number:	CM15-0172538		
Date Assigned:	09/14/2015	Date of Injury:	05/18/2011
Decision Date:	11/09/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/01/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 43 year old female who sustained an industrial injury on 05-18-2011. The injured worker was diagnosed with right rotator cuff syndrome, lumbar disc herniation and right internal derangement of the knee. According to the primary treating physician's progress report on July 30, 2015, the injured worker continues to experience pain associated with numbness and tingling in the bilateral shoulders, arms, elbows, hands, wrists, lumbar spine, hips, sacroiliacs, buttocks, legs, knees, ankles and feet. The injured worker rated her current discomfort as 9 out of 10 on the pain scale approximately 85% of the time. The discomfort at its worst is 10 out of 10 and at its best is 8 out of 10 on the pain scale. The injured worker also reported anxiety, stress and insomnia. Objective findings consisted of a height of 177cm tall and a weight of 219 pounds. There was tenderness to palpation at the lumbar area, bilateral sacroiliacs, sacrum, bilateral buttocks, bilateral posterior legs and bilateral anterior shoulder. Lumbar range of motion was noted as flexion at 35 degrees, extension at 10 degrees, bilateral lateral flexion and bilateral rotation at 10 degrees each. Positive sitting root and Braggard's signs were noted. Straight leg raise was positive at 40 degrees on the right and 45 degrees on the left. Right shoulder range of motion was noted as flexion at 150 degrees, extension at 35 degrees, abduction at 150 degrees, adduction at 35 degrees and bilateral internal and external rotation at 65 degrees each. Examination of the knees demonstrated tenderness to palpation of the left medial joint line with crepitus and edema. Range of motion was noted as left knee flexion at 110 degrees and right flexion at 120 degrees and bilateral extension at 0 degrees. McMurray's was positive on the left. Prior treatments documented to date have included

acupuncture therapy and medications. There were no dates or reports of last radiological or magnetic resonance imaging (MRI)s performed. Current medications were listed as Norco 10mg-325mg and Cyclobenzaprine. Treatment plan consists of recommending continuing with acupuncture therapy, continuing with modified work duties and restrictions and on July 30, 2015 requested authorization for updated lumbar spine magnetic resonance imaging (MRI), updated right knee magnetic resonance imaging (MRI), updated right shoulder magnetic resonance imaging (MRI), CAPS-STGC topical compound cream, 180gm and Norco 10mg-325mg twice a day #80. On August 7, 2015, the Utilization Review determined the request to be non-certified for updated lumbar spine magnetic resonance imaging (MRI), updated right knee magnetic resonance imaging (MRI), and updated right shoulder magnetic resonance imaging (MRI), CAPS-STGC topical compound cream, 180gm and Norco 10mg-325mg twice a day #80.

IMR ISSUES, DECISIONS AND RATIONALES

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

Updated MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria.

Decision rationale: According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication for a repeat MRI of the lumbar spine. In this case, there are no new findings on exam and the medical records do not include the previous MRI to compare with the current objective examination findings. Medical necessity for the requested repeat MRI of the lumbar spine is not established. The requested study is not medically necessary.

Updated MRI right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI shoulder.

Decision rationale: The ODG states that an MRI of the shoulder is indicated for the evaluation of acute shoulder trauma, suspected rotator cuff tear/impingement, in patients over age 40 with normal plain radiographs, subacute shoulder pain, and suspected instability/labral tear. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, there are no new findings on exam and the medical records do not include the previous MRI to compare with the current objective examination findings. Medical necessity for the requested repeat MRI of the shoulder is not established. The requested study is not medically necessary.

Updated MRI right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI knee.

Decision rationale: According to the ODG, indications for imaging of the knee include, acute trauma to the knee and non-traumatic knee pain. Soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MRI. MRI scans are accurate to diagnose meniscus tears, but MRI is a poor predictor of whether or not the tear can be repaired. Studies showed that MRI studies are necessary if they are indicated by history and/or physical examination to assess for meniscal, ligamentous, or osteochondral injury or osteonecrosis, or if the patient had an unexpected finding that affected treatment. In this case, there are no new findings on exam and the medical records do not include the previous MRI to compare with the current objective examination findings. Medical necessity for the requested repeat MRI of the knee is not established. The requested study is not medically necessary.

CAPS-STGC 180gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, this medication contains: capsaicin, tramadol, cyclobenzaprine, gabapentin, and menthol. MTUS states that capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Gabapentin and Tramadol are not FDA approved for a topical application. Cyclobenzaprine is not FDA approved for use as a topical application. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Norco 10/325mg 1 tab po bid #80: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. There is no documentation of significant pain relief or increased function from the opioids used to date. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.