

Case Number:	CM15-0175371		
Date Assigned:	09/16/2015	Date of Injury:	10/03/2011
Decision Date:	10/19/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/04/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 49 year old female with an industrial injury dated 10-03-2011. Medical record review indicates she was being treated for status post bilateral shoulder surgery with residuals, status post right elbow lateral release surgery with residuals and status post right wrist surgery with residuals. She presents on 07-10-2015 with complaints of pain in bilateral shoulders, right elbow and pain and numbness in the right wrist. Right shoulder was rated 6 out of 10 on the visual analog scale "which has increased from 5 out of 10 last visit." Left shoulder pain is documented as 5 out of 10 "which has remained the same since her last visit; right elbow pain was rated as 5 out of 10 "which has increased from 4 out of 10 on the last visit"; and right wrist pain was rated as 6 out of 10 "which has increased from 4 out of 10 on the last visit." Physical exam noted grade 2 tenderness to palpation "which has remained the same since her last visit. Range of motion was documented as restricted and impingement and supraspinatus test were documented as positive on the right. Right elbow exam documented grade 2 tenderness to palpation "which has remained the same since her last visit. Right wrist revealed grade 2 tenderness to palpation "which has remained the same since his last visit." Tinel's sign and Phalen's test are documented as positive. Prior treatments are documented as physical therapy and medications. Urine drug screen is documented as done on 07-24-2014. Diagnostics documented in the 07-10-2015 note included: Multi-position MRI of the right shoulder with arthrogram (05-02-2014) is documented as showing (1) Supraspinatus partial tear (2) Infrapinatus partial tear (3) SLAP type one half-lesion (4) Biceps tendinopathy (5) Acromioclavicular joint osteoarthritis (6) Subacromial bursitis. - Electro diagnostic studies of

the cervical spine and upper extremities (04-29-2014) -(1) The study showed no acute or chronic denervation potentials in any of the muscles tested (2) The study did not reveal any electrophysiological evidence of peripheral nerve entrapment. The treatment request is for urine toxicology and MRI, right shoulder. On 08-07-2015 the request for urine toxicology and MRI, right shoulder were non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI, right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on shoulder complaints states: Primary criteria for ordering imaging studies are: Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems). Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon). Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment) The patient has no red flags on exam and no new physiologic deficits since last MRI. There are no planned invasive surgeries. Therefore, the request is not medically necessary.

Urine toxicology: Overturned

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 rationale: The California chronic pain medical treatment guidelines section on opioids states: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as

most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)

(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.

(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.

(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).

(g) Continuing review of overall situation with regard to non-opioid means of pain control.

(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids. The patient was on opioids at the time of request and therefore the request is medically necessary.