MAXIMUS Federal Services

Case Number:	CM15-0060302		
Date Assigned:	04/06/2015	Date of Injury:	12/31/1996
Decision Date:	05/27/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	03/30/2015

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 45 year old female, who sustained an industrial injury on 12/31/1996, due to reported repetitive motion. The injured worker was diagnosed as having post-surgical left shoulder x4, post-surgical right hand x4, complex regional pain syndrome, right hand muscle wasting, reflex sympathetic dystrophy, right upper extremity tremor, thoracic syndrome, depression, and sleep disorder. Treatment to date has included multiple surgical interventions, physical therapy, transcutaneous electrical nerve stimulation unit, and medications. The latest physician progress note submitted for review was documented on 10/21/2014. The injured worker presented with complaints of left shoulder pain, neck pain, low back pain, and right hip pain. The injured worker indicated that previous hand therapy had not relieved symptoms. The injured worker had been given a home exercise regimen; however, she was not performing the exercises as directed. The injured worker reported 3/10 pain with medication and 8/10 without medication. There was no comprehensive physical examination provided. The treatment recommendations included a urine drug screen, a refill of Norco, tramadol, Percura, Gabadone, Sentra AM, Pamelor, FluriFlex ointment, ibuprofen, Butrans, and a continuation of TENS therapy. A Request for Authorization form was then submitted on 10/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI arthrogram bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder MR arthrogram.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state that for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. There was no comprehensive physical examination provided for this review. There was no indication that this injured worker has exhausted conservative treatment for the bilateral shoulders prior to the request for an imaging study. The medical necessity has not been established. As such, this request is not medically necessary

1 MRI cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state that for most patients presenting with true neck and upper back problems, special studies are not needed unless a 3 to 4 week period of conservative care and observation fails to improve symptoms. There was no documentation of a recent physical examination of the cervical spine. There was no indication that this injured worker has exhausted conservative treatment for the cervical spine prior to the request for an imaging study. Given the above, the request is not medically necessary.

Elavil 25mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tricyclic anti-depressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: The California MTUS Guidelines state amitriptyline is recommended for neuropathic pain. In this case, it was noted that the injured worker is currently utilizing Pamelor 25 mg. There was no indication that the injured worker is currently utilizing Elavil 25 mg. There was also no frequency or quantity listed in the request. As such, this request is not medically necessary.

Lidocaine patch 4%: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Lidoderm (lidocaine patch).

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

Decision rationale: The California MTUS Guidelines state lidocaine is recommended for localized peripheral pain or neuropathic pain after there has been evidence of a trial of first line treatment with tricyclic antidepressants or an anticonvulsant. In this case, there was no documentation of a failure to respond to first line oral medications prior to the initiation of a topical analgesic. There was also no frequency or quantity listed in the request. As such, this request is not medically necessary.