

Case Number:	CM15-0093156		
Date Assigned:	05/20/2015	Date of Injury:	06/26/2013
Decision Date:	08/18/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/15/2015

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: Orthopedic Surgery

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 59-year-old female, who sustained an industrial injury on 6/26/13. Initial complaints were not reviewed. The injured worker was diagnosed as having right shoulder pain late effect of closed humeral fracture/status post open reduction internal fixation (ORIF) with adhesive capsulitis; impingement syndrome left shoulder; right knee sprain; chronic pain syndrome. Treatment to date has included medications. Diagnostics included X-rays right shoulder (9/5/13); CT scan right shoulder (4/24/14 and 1/5/15); EMG/NCV study upper extremities (10/8/14). Currently, the PR-2 notes dated 3/5/15 indicated the injured worker is in this office for her right shoulder. She is a status post humeral fracture and open reduction internal fixation (ORIF) surgery. She complains of persistent right shoulder pain and weakness. A CT scan was requested. A MRI of the right shoulder was done on 1/5/15 but the impression was distorted due to the amount of metal artifact, it was difficult to determine any important facts. The injured worker describes her shoulder pain as on and off; cold weather and activity increase pain. She has significant weakness in the right upper extremity. She is here for a medications refill. Objective findings reveal tenderness and pain to the right shoulder, rotator cuff and bicep tendon with weakness against resistance, 4+/5 abduction and external rotation; internal rotation 5-/5. She has tenderness along the rotator cuff and bicep tendon with positive impingement and Hawkin's sign.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hinged right knee orthosis indefinite use: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, Knee Brace.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

Decision rationale: CA MTUS / ACOEM Chapter 13 Knee complaints, page 340 states that a brace can be used for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability although its benefits may be more emotional than medical. According to the ODG, Knee chapter, Knee brace section, knee braces may be appropriate in patients with one of the following conditions: knee instability, ligament insufficiency/deficiency, reconstructed ligament, articular defect repair, avascular necrosis, and specific surgical interventions. The cited medical records of 3/5/15 demonstrate the claimant is not experiencing specific laxity, instability, and ligament issues or has undergone recent surgical intervention. Therefore, the request for durable medical equipment, hinged knee orthosis, is not medically necessary and appropriate.

MRI cervical spine w/o contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: According to the CA MTUS/ACOEM Chapter 8, Neck and Upper Back Complaints pgs 177-178 regarding special studies (MRI), recommendations are made for MRI of cervical or thoracic spine when conservative care has failed over a 3-4 week period. Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. In this case, the exam notes cited from 3/5/15 do not demonstrate any deficit neurologically or failed strengthening program prior to the request for MRI of the cervical spine. Therefore, the determination is for non-certification as not medically necessary.

Fluoroscopy cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Office visits.

Decision rationale: CA MTUS/ACOEM is silent on office visits. According to the ODG Pain section, Office visits, Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In this case, the exam note from 3/5/15 does not demonstrate complex diagnosis, failure of non-operative management or objective rationale to justify fluoroscopy of the cervical spine. Therefore, the determination is not medically necessary.

Cervical traction unit with air bladder indefinite use: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck section, Traction.

Decision rationale: The Official Disability Guidelines, Neck section, traction, recommend home cervical patient-controlled traction units for patients with radicular symptoms in conjunction with a home exercise program. The clinical documentation submitted for review from 3/5/15 does not demonstrate clear evidence of cervical radiculopathy. The request as submitted failed to indicate if the unit was for purchase or rental. Additionally, it failed to provide the duration for the requested service. As the guideline criteria have not been met, the determination is not medically necessary.

Conductive garment for TENS unit indefinite use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 113-114.

Decision rationale: According to the California MTUS Chronic Pain Medical Treatment Guideline regarding TENS, pages 113-114, chronic pain (transcutaneous electrical nerve

stimulation), "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for neuropathic pain and CRPS II and for CRPS I (with basically no literature to support use)." Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. In this case there is insufficient evidence of chronic neuropathic pain from the exam note of 3/5/15 to warrant a TENS unit. There also is no evidence of an evidence based functional restoration plan. Therefore the determination is not medically necessary for the associated conductive garment for TENS unit.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94 & 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 93-94.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence in the records of 3/5/15 of failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore, use of Tramadol is not medically necessary and it is noncertified.