

Case Number:	CM15-0128616		
Date Assigned:	07/15/2015	Date of Injury:	02/01/2011
Decision Date:	10/02/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	07/03/2015

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: Preventive Medicine, Occupational Medicine

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 34 year old who sustained an injury on 2-1-2011. Initial symptoms and complaints are not included in the medical records. An orthopedic exam on 5-8-15 reports the IW has persistent pain of the neck that radiates to the upper extremities with numbness and tingling. In addition, there is constant pain in the cervical spine aggravated by repetitive motions of the neck. The pain is rated as 7 out of 10. There is constant pain in the back that is rated as 7 out of 10 also. There is frequent pain in the bilateral wrists aggravated by repetitive motions and the pain is rated 5 out of 10. Diagnoses include Cervical Discopathy with Radiculitis, Lumbar Discopathy with Radiculitis, Carpal Tunnel Syndrome, Double Crush and Right Shoulder Impingement Syndrome. The treatment plan is physical therapy, MRI cervical spine. No additional information is available for review. Current requested treatment is MRI of the right shoulder, MRI of cervical spine. On 6/4/15, a standardized form with checked boxes for various medications was reviewed. The form is not specific for this individual. Medications include Ondansetron, unspecified, Cyclobenzaprine, unspecified, Tramadol, unspecified, Sumatriptan, unspecified.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207, 208.

Decision rationale: MTUS Guidelines support a shoulder MRI if there is has been a progressive strengthening program, but there is persistent pain and weakness. These conditions are not documented in the records reviewed. There is no record of a reasonable attempt of rehabilitation with physical therapy prior to this request for a shoulder MRI. There are no "red flag" conditions documented that would support an exception to the Guideline recommendations for a prolonged attempt at conservative care initially before MRI studies. Under these circumstances, the MRI of the right shoulder is not supported by Guidelines and is not medically necessary.

MRI of cervical spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines, MRI.

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

Decision rationale: MTUS Guidelines support cervical MRI scans if there is persistent signs and symptoms of neurological dysfunction. This individual meets these Guideline criteria with the documented signs and symptoms consistent with a radiculopathy. Under these circumstances, the request for the cervical MRI is supported by Guidelines and is medically necessary.

Physical Therapy, twice a week for four weeks for the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: MTUS Guidelines recommend that up to 10 sessions of physical therapy are appropriate for this individual's condition. The limited records for review do not document the extent of any prior physical therapy. Without documentation of prior therapy that meets Guideline support, the request for Physical Therapy, twice a week for four weeks for the cervical spine is within Guideline recommendations. The requested Physical Therapy is not medically necessary.

Ondansetron, unspecified: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation PubMed: Zofran.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23-27. Decision based on Non-MTUS Citation <http://www.rxlist.com/zofran-drug/indications-dosage.htm>.

Decision rationale: MTUS Guidelines have recommended minimal standards to establish a diagnosis and recommended treatment. These standards have not been met in relationship to this requested. The FDA and supported use of this drug is for immediate post operative care for nausea, nausea associated with cancer treatment, or intractable nausea and vomiting from acute gastritis. This individual does not meet the FDA criteria for use and there are no unusual circumstances to justify an exception to Guidelines and standard recommendations. The Ondansetron (Zofran), unspecified is not medically necessary.

Cyclobenzaprine, unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 64.

Decision rationale: MTUS Guidelines do not support the prolonged use of muscle relaxants for chronic pain / conditions. The recommended daily use is limited up to 3wks and if highly beneficial only short term limited use for flare-ups is recommended thereafter. The muscle relaxant appears to be recommended for long term daily use and is being dispensed as such. There are no unusual circumstances to justify an exception to Guidelines. The Cyclobenzaprine, unspecified is not supported by Guidelines and is not medically necessary.

Tramadol, unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

Decision rationale: The MTUS Guidelines have very specific standards that recommended justify the use of opioid medications. These standards include a review of prior opioid use a benefit, screening for risk factors of potential misuse, review of alternatives trialed and reason for failure. These Guideline standards have not been met in relationship to the dispensed Tramadol. There no documentation of prior medication treatment, risk for misuse, pain relief, or functional benefits from opioid use. Under these circumstances, the Tramadol, unspecified is not medically necessary and is not supported by Guidelines.

Sumatriptan, unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Imitrex.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23, 24. Decision based on Non-MTUS Citation <http://sumatriptan.com/>.

Decision rationale: MTUS Guidelines recommend a minimal standard of evaluation to support a medical diagnosis and treatment. These standards have not been met in this individual. This drug's recommended use is only for the well established diagnosis of migraine headaches that is non-responsive to prior treatments. There is a statement that this individual has headaches migraine in nature, but the exact symptoms, nature, frequency, location and prior treatments are not documented. This is a drug with a dangerous side effect profile and its use should be well justified for the risk involved. At this point in time, the evaluation is inadequate to meet Guideline standards to justify the use of Sumatriptan, unspecified. The Sumatriptan is not medically necessary.