

Case Number:	CM13-0020114		
Date Assigned:	10/11/2013	Date of Injury:	12/22/2010
Decision Date:	01/15/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	09/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 52-year-old female who reported a work-related injury on 12/22/2010 due to using heavy equipment at work. The patient's diagnoses include cervical disc syndrome with radicular syndrome, left shoulder internal derangement, lumbar spine spondylosis, low back syndrome with radicular symptoms, right knee medial meniscal tear, right knee osteoarthritis/degenerative joint disease, insomnia, depression, and hypertension. The patient's medications include Omeprazole, Nabumetone, and Cyclobenzaprine. The patient has undergone physical therapy sessions and work conditioning. The current request is for MRI of the right shoulder, 1 prescription of Nabumetone 750 mg, 1 electromyogram, 1 nerve conduction velocity, and 1 unknown prescription of unknown topical cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

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

Decision rationale: The clinical note dated, 07/09/2013, revealed objective findings of foraminal compression test, distraction test, and shoulder depression test were all positive bilaterally. The clinical note dated, 08/13/2013, revealed impingement test, Neers test, Hawkins-Kennedy test, and empty can supraspinatus tests were all negative in the right shoulder. The right shoulder was noted to have normal range of motion during testing. The patient reported on this date that she had engaged in 20 sessions of physical therapy and noted that physical therapy provided no relief. The California Medical Treatment Guidelines for shoulder complaints state the primary criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. There is a lack of objective and subjective evidence noted to support the imaging of the right shoulder. There is a lack of documentation submitted with the review stating the patient had failed conservative care for the right shoulder, to include therapy for the right shoulder, medications, and exercise. The patient does not meet the criteria set by the guidelines for ordering imaging studies. As such, the request for MRI of the right shoulder is non-certified.

Nabumetone 750mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

Decision rationale: The clinical note dated, 08/13/2013, states that the patient presented with complaints of neck pain and left shoulder pain. She also complained of lower back pain and right knee pain and stated she had numbness and tingling sensations in both legs, as well as weakness in the right knee. The patient also complained of constant headaches, anxiety, depression, stress, sleep disturbance, weight gain, and elevated blood pressure. The clinical note dated, 06/04/2013, noted that the patient's allergies included Relafen. The request is for Nabumetone, which is a generic of Relafen. The patient was noted to have a history of acid reflux and a noted possible allergic reaction to the name brand Relafen. The California Medical Treatment Guidelines for Chronic Pain indicates that it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time due to side effects of NSAIDs. All NSAIDs are noted to have the potential to raise blood pressure in susceptible patients. They are also noted to cause GI events in patients. The California Medical Treatment Guidelines indicate that NSAIDs are recommended as an option for short-term symptomatic relief for back pain. There is no evidence for the use of these medications to treat long-term neuropathic pain. Given the above, the request for 1 prescription of Nabumetone 750 mg #90 is non-certified.

Electromyogram (EMG): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 296-297.

Decision rationale: The request was noted as 1 electromyogram. It was not noted in the request the area to be tested. The clinical note dated, 08/15/2013, stated that the patient was complaining of unrelenting abnormal sensation in both her legs. This note stated that EMG/NCV studies must be obtained for objective and reliable information regarding the patient's physiological, nerve, and muscle function. The most recent physical exam findings noted decreased sensation over the right L5 and S1 dermatomes with positive Valsalva and Kemp's test. There was also positive supine straight leg raise testing on the right. The California Medical Treatment Guidelines indicate that no testing is recommended unless compression is severe or progressive for lumbosacral nerve root compression with radiculopathy. There was a lack of documentation submitted stating the patient's symptoms were severe or progressive in nature. The clinical documentation presented does not support the request for 1 electromyogram. As such, the request for 1 electromyogram is non-certified.

Nerve Conduction Velocity (NCV): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back
Chapter, Nerve Conduction Studies.

Decision rationale: The area of the body for the NCV test was not noted in the request. The clinical note dated, 08/15/2013, stated that the patient has complained of significant and persistent numbness sensation, weakness and tingling sensation in both her legs. Electrodiagnostic study was therefore requested to evaluate the extent of the compression over both extremities. The California Medical Treatment Guidelines indicate that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. There was no documentation presented noting the efficacy of the patient's prior conservative care for her radicular symptoms. The patient was also not noted to be considering surgery. Official Disability Guidelines further state that nerve conduction studies are not recommended for low back conditions. Guidelines further state there is minimal justification for performing nerve conduction studies when a patient is presumed by have symptoms on the basis of radiculopathy. Given the above, the request for 1 nerve conduction velocity is non-certified.

Topical cream (unspecified): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The name, amount, and quantity of the topical cream requested were not identified. The clinical note dated, 08/15/2013, stated that the requested topical cream was scientifically-proven and recommended in pain alleviation. The doctor noted that the patient was prescribed the topical cream because it could help temporarily relieve her aches and pains. The California Medical Treatment Guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Guidelines further state that many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, and anti-depressants. There is little to no research to support the use of many of these agents. It is unknown what ingredients are in the topical analgesic the patient is being prescribed. As such, the request for unknown prescription of unknown topical cream is non-certified.