

Case Number:	CM13-0020336		
Date Assigned:	10/11/2013	Date of Injury:	07/18/2012
Decision Date:	01/15/2014	UR Denial Date:	08/27/2013
Priority:	Standard	Application Received:	09/05/2013

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 56-year-old female who sustained an occupational injury on 07/08/2012 after developing gradual pain as the result of driving and carrying heavy boxes. The patient's diagnoses include post-traumatic outlet syndrome with adhesive capsulitis, vascular headaches, and associated double crush syndrome and tenosynovitis of the upper extremity. The patient's treatment history includes left shoulder surgery with [REDACTED] on 02/11/2013 with 36 sessions of physical therapy, activity modifications, and oral/topical medications. According to the documentation presented for review from 07/02/2013, the patient presents with complaints of left shoulder/left neck pain rated an 8/10 in severity, which she indicates is constant, sharp, stabbing, and radiates to the upper extremities with weakness and numbness associated. Objective documentation from that day revealed classic findings of post-traumatic thoracic outlet syndrome. The physician request at that time was for proper diagnostic studies to be completed to include a soft tissue ultrasound of the brachial plexus with Doppler flow studies in order for the physician to make informed decisions regarding the patient's future treatment recommendations. A left shoulder Doppler ultrasound dated 08/15/2013 was completed and said to be limited due to the tech's inability to touch the area secondary to extreme pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Left Brachial Plexus without Contrast: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79,81,111,113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

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

Decision rationale: California MTUS/ACOEM indicates that for most patients presenting with true neck or upper back problems, special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. Most patients improve quickly provided any red flag conditions are ruled out. However, criteria for ordering imaging studies are: (1) emergence of a red flag; (2) physiologic evidence of tissue insult or neurologic dysfunction; (3) failure to progress in a strengthening program intended to avoid surgery; (4) clarification of the anatomy prior to an invasive procedure. According to the documentation submitted for review from 07/02/2013, the patient presents for followup with objective documentation indicating she has classic findings of post-traumatic thoracic outlet syndrome. The patient had severe scalene tenderness, Tinel's with percussion over the brachial plexus and very painful costoclavicular abduction testing. The physician requested an ultrasound of the brachial plexus in order to make informed decisions regarding the patient's further treatment recommendations. However, the results of this test were limited due to the sonogram tech's inability to touch the area secondary to patient pain. Guidelines further indicate that unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear; however, further physiologic evidence of nerve dysfunction can be obtained by ordering an imaging study. Magnetic resonance imaging is stated to be the mainstay of plexus imaging and has been shown to detect features of intraneural anatomy not previously seen with earlier diagnostic imaging studies and to localize pathologic lesions and conditions where electrophysiologic and physical findings are non-specific or non-localizing. Given the patient's ongoing subjective complaints of severe pain with objective evidence of post-traumatic thoracic outlet syndrome, the MRI Left Brachial Plexus without Contrast is supported.

Tylenol No. 3 1 tablet p.o.q. hours prn 60 tablets: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-92.

Decision rationale: The California MTUS indicates that chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should be done with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added. Furthermore, Guidelines recommend ongoing monitoring and assessment of the 4 A's including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. According to the documentation submitted for review from 07/02/2013, the patient does have

complaints of ongoing severe left shoulder and left neck pain rated as an 8/10 in severity. Furthermore, objective documentation on that day revealed findings that were consistent with post-traumatic thoracic outlet syndrome with severe scalene tenderness, Tinel's with percussion over the brachial plexus, and very painful costoclavicular abduction testing. The physician indicated that these findings were suggestive of a very symptomatic thoracic outlet syndrome. While the use of an oral opioid analgesic may be indicated for use of pain control in this patient, the request as written specifically indicates Tylenol No. 3 1 tablet p.o. q. hours prn 60 tablets. Guidelines indicate that analgesic dosing of Tylenol No. 3 are 15 mg to 60 mg of codeine per dose and 300 mg to 1000 mg of acetaminophen per dose. Doses may be given as needed up to every 4 hours. While the patient's condition may benefit from use of such medication, without specific dosing instructions regarding frequency of use, this request cannot be supported.