

Case Number:	CM13-0040864		
Date Assigned:	12/20/2013	Date of Injury:	10/19/2012
Decision Date:	03/20/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	10/29/2013

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, has a subspecialty in Interventional Spine 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 59-year-old female with a date of injury of 10/19/2012. The list of diagnoses per [REDACTED] dated 10/03/2013 are: 1. Cervical spine sprain/strain with left upper extremity radiculitis, rule out disk bulges; 2. Left shoulder sprain/strain with impingement syndrome and evidence of multiple partial tears of the supraspinatus tendon per MRI scan dated 11/28/2012; and 3. Left elbow strain, rule out cubital tunnel syndrome. According to report dated 10/03/2013 by [REDACTED], the patient presents with neck and left shoulder pain. Patient reports that her prior complaints of the right hip have subsided; however, her neck and left shoulder and upper extremity pains continue. The patient describes neck pain that is radiating with numbness, and tingling into the left upper extremity down to the left hand. The patient also states left shoulder, arm, and hand pain with numbness and tingling. The right shoulder pain is secondary to overcompensation. An examination of the bilateral shoulders reveals mild atrophy over the left supraspinatus muscle. Tenderness to palpation is present over the subacromial region. An impingement test and cross-arm test are positive on the right side. Active range of motion of the bilateral shoulders is measured as flexion 172, extension 40, abduction 168, adduction 40, internal rotation 80, and external rotation 75 on the left side. An examination of the cervical spine reveals a decrease in the normal cervical lordotic curvature, tenderness to palpation with muscle spasm and muscle guarding present over the paravertebral and trapezoidal musculature. The axial compression test was noted as negative. Active range of motion of the cervical spine was noted a decreased in all range. Sensation to pinprick and light touch in the right upper extremity is intact. Sensation to pinprick and light touch in the left upper extremity is decreased over the left median nerve distribution and there is hypersensitivity over the left forearm in "a patchy distribution."

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the neck, three (3) times a week for four (4) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

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

Decision rationale: The patient presents with neck and left shoulder pain. The treater requests physical therapy to "treat the neck, to decrease pain and increase active range of motion." The utilization review dated, 10/21/2013 denied the request stating patient is noted with complaints of pain in the "left shoulder." The Chronic Pain Guidelines recommend nine to ten (9 to 10) visits for myalgia, myositis, and neuralgia type symptoms. The medical records show that the patient's complaints of neck pain are more recent and not discussed at prior qualified medical exam (QME) reports, dated 03/06/2013 and 04/29/2013. Given the patient's complaints of neck pain and decreased range of motion, physical therapy may be warranted. However, the requested twelve (12) sessions exceeds what is recommended by the guidelines. Recommendation is for denial.

Physical therapy to the left shoulder, two (2) times a week for four (4) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

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

Decision rationale: This patient presents with neck and left shoulder pain. Treater requests physical therapy to "treat the left shoulder to increase strength and to progress to a home exercise program". The utilization review, dated 10/21/2013 modifies certification to two (2) visits for "limited re-treatment and re-education". The Chronic Pain Guidelines recommend nine to ten (9 to 10) visits for myalgia and myositis and neuralgia type symptoms. According to the qualified medical exam (QME) report, dated 03/06/2013, there are references to the patient receiving physical therapy for the shoulder in reports dated 10/28/2012, 11/02/2012, 11/07/2012, 11/14/2012, 12/20/2012 and 01/24/2013. In this case, there is no documentation that clearly states the exact number of physical therapy sessions received. However, it is clear that patient has a long history with physical therapy. The patient appears to have a good range of motion as well and there does not appear to be any reason why the patient should now be well versed with the exercise regimen to increase strength and perform home exercises. Recommendation is for denial.

. MRI of the cervical spine: Upheld

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

MAXIMUS 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 (ODG)

Decision rationale: The patient presents with neck and left shoulder pain. The treater requests cervical spine MRI to rule out degenerative disk disease and disk bulges. The MTUS/ACOEM Guidelines indicate the following criteria for ordering imaging studies: Emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in strengthening program intended to avoid surgery, and clarification of anatomy prior to an invasive procedure. The guidelines may be more appropriately applied for acute and sub acute cases. For a chronic condition, the Official Disability Guidelines recommend MRI studies for chronic neck pain after three (3) months of conservative treatment when radiographs are normal and neurologic signs or symptoms are present. There is a report of a shoulder MRI from 11/28/13, but no evidence of an MRI of the cervical spine thus far. This patient presents with radiating pain down the arm. Given that the patient has failed to improve with conservative care with persistent neurologic symptoms, an MRI of the cervical spine at this juncture is consistent with ODG guidelines recommendation. Recommendation is for authorization.

Electromyography (EMG) of the left upper extremity: Overturned

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

MAXIMUS 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 (ODG).

Decision rationale: This patient presents with neck and left shoulder pain. The treater requests EMG/NCV of the left upper extremity to rule out radiculopathy versus peripheral neuropathy due to complaints of numbness and tingling into the left 4th and 5th fingers and positive clinical findings. The utilization review dated, 10/21/2013 denied the request stating "no noted significant neurological deficits". The MTUS/ACOEM Guidelines state that "when the neurologic examination is less clear; however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV... may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3-4 weeks." In this case, the symptoms have lasted long-term, and the patient has failed conservative care. Recommendation is for authorization.

Nerve Conduction Velocity (NCV) of the left upper extremity: Overturned

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

MAXIMUS 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 (ODG).

Decision rationale: This patient presents with neck and left shoulder pain. The treater requests EMG/NCV of the left upper extremity to rule out radiculopathy versus peripheral neuropathy due to complaints of numbness and tingling into the left 4th and 5th fingers and positive clinical findings. The utilization review dated, 10/21/2013 denied the request stating "no noted significant neurological deficits". The MTUS/ACOEM Guidelines state that "when the neurologic examination is less clear; however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV... may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3-4 weeks." In this case, the symptoms have lasted long-term, and the patient has failed conservative care. Recommendation is for authorization.

Neurontin 300mg #60 i: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gaborone, generic available), Page(s): 18-19.

Decision rationale: The patient presents with neck and left shoulder pain. The treater requests Neurontin 300 mg #60. The utilization review, dated 10/21/2013 denied the request stating, "This claimant is not documented to have diabetic painful neuropathy and/or postherpetic neuralgia." The Chronic Pain Guidelines indicate that gabapentin (Neurontin, Gaborone) has been shown to be effective for treatment of diabetic painful neuropathy and post therapeutic neuralgia and has been considered as a first-line treatment for neuropathic pain. In this case, the patient has radiating pain accompanied with tingling and numbness which is neuropathic. The requested Neurontin is medically necessary and recommendation is for approval.

Voltaren XR 100mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications and NSAIDs (non-steroidal anti-inflammatory drugs), Page(s): 22, 6.

Decision rationale: The patient presents with neck and left shoulder pain. The treater is requesting Voltaren XR 100 mg #30. The utilization review, dated 10/21/2013 denied the request stating "NSAIDs are recommended for only short-term use and not applicable to an (OTC) NSAIDs has not been documented". The Chronic Pain Guidelines indicate that for non-steroidal anti-inflammatory drugs (NSAIDs), it is recommended that the lowest dose for the

shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain and in particular for those with gastrointestinal, cardiovascular, or renal vascular risk factors. The guidelines also support the use of NSAIDS for chronic lower back pain as a first line of treatment. Given this is a first line of treatment for back pain and patient is not on any other pain medication, Voltaren is considered medically necessary and recommendation is for approval.