MAXIMUS Federal Services

Case Number:	CM13-0043800		
Date Assigned:	12/27/2013	Date of Injury:	05/30/2013
Decision Date:	02/24/2014	UR Denial Date:	10/12/2013
Priority:	Standard	Application Received:	10/31/2013

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 Pain Management 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:

This is a female patient with a date of injury of 5/30/13. A utilization review determination dated 10/12/13 recommends non-certification of MRIs of the cervical spine and shoulder, EMG/NCV (electromyogram and nerve conduction Studies) of the bilateral upper extremities, omeprazole, orphenadrine, and Medrox. A progress report dated 9/24/13 identifies subjective complaints including neck pain radiating to the arms and hands with numbness and tingling as well as frequent headaches associated with her neck pain. There is continuous pain in the shoulder traveling to the left wrist and hand with numbness and tingling. There is continuous left wrist/hand pain with swelling, numbness, tingling, cramping, and weakness. She is having difficulty sleeping and is unable to find a comfortable position secondary to her pain. She suffers from bouts of depression, stress, and anxiety. She feels sadness, frustration, desperation, anguish, anger, and uselessness. No treatment has apparently been done to date. Objective examination findings identify paravertebral tenderness and spasm with limited Range Of Motion. Sensation is reduced in the bilateral median nerve distribution. Anterior shoulder is tender to palpation and there is limited forward flexion and abduction on the left with positive impingement sign. Grip strength is reduced bilaterally and sensation is reduced in the bilateral median nerve distribution with positive Phalen's and Tinel's tests. Diagnoses include cervical spine strain, left shoulder impingement syndrome, and bilateral carpal tunnel syndrome. Treatment plan recommends diagnostic studies to determine ulnar nerve pathology, MRI of the cervical spine to rule out herniated disc and compression neuropathies, MRI of the left shoulder to rule out rotator cuff tear, EMG/NCS of the bilateral upper extremities to rule out entrapment neuropathy versus radiculopathy, physical therapy 3 x 4 to the neck and left shoulder, Ketoprofen, Omeprazole, Medrox, and Orp

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Cervical Spine Qty 1.00: 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): 176-177.

Decision rationale: Regarding the request for MRI cervical spine, Chronic Pain Medical Treatment Guidelines supports special studies such as MRI in the absence of red flags only after failure of 3-4 weeks of conservative treatment. Within the documentation available for review, there are no red flags noted, there is documentation that no treatment had been previously rendered, and conservative treatment in the form of physical therapy and medication was concurrently recommended at the time of this current request. In light of the above issues, the currently requested MRI cervical spine is not medically necessary.

MRI Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

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

Decision rationale: Regarding the request for MRI left shoulder, Chronic Pain Medical Treatment Guidelines, supports special studies such as MRI in the absence of red flags only after failure of conservative treatment in the presence of a potential surgical lesion and/or other serious pathology. Within the documentation available for review, there are no red flags noted, there is documentation that no treatment had been previously rendered, and conservative treatment in the form of physical therapy and medication was concurrently recommended at the time of this current request. In light of the above issues, the currently requested MRI left shoulder is not medically necessary.

EMG (Electromyogram) Right Upper Extremity 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

Decision rationale: Regarding the request for EMG (Electromyogram) right upper extremity, Chronic Pain Medical Treatment Guidelines, supports special studies such as electrodiagnostic

studies in the absence of red flags only after failure of 3-4 weeks of conservative treatment. Within the documentation available for review, there are no red flags noted, there is documentation that no treatment had been previously rendered, and conservative treatment in the form of physical therapy and medication was concurrently recommended at the time of this current request. In light of the above issues, the currently requested EMG right upper extremity is not medically necessary.

EMG (Electromyogram) Left Upper Extremity 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

Decision rationale: Regarding the request for EMG left upper extremity, Chronic Pain Medical Treatment Guidelines, supports special studies such as electrodiagnostic studies in the absence of red flags only after failure of 3-4 weeks of conservative treatment. Within the documentation available for review, there are no red flags noted, there is documentation that no treatment had been previously rendered, and conservative treatment in the form of physical therapy and medication was concurrently recommended at the time of this current request. In light of the above issues, the currently requested EMG left upper extremity is not medically necessary

NCV (Nerve Conduction Studies) Right Upper Extremity Qty 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

Decision rationale: Regarding the request for NCV right upper extremity, Chronic Pain Medical Treatment Guidelines, supports special studies such as electrodiagnostic studies in the absence of red flags only after failure of 3-4 weeks of conservative treatment. Within the documentation available for review, there are no red flags noted, there is documentation that no treatment had been previously rendered, and conservative treatment in the form of physical therapy and medication was concurrently recommended at the time of this current request. In light of the above issues, the currently requested NCV right upper extremity is not medically necessary.

NCV (Nerve Conduction Studies) Left Upper Extremity Qty 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

Decision rationale: Regarding the request for NCV left upper extremity, Chronic Pain Medical Treatment Guidelines, supports special studies such as electrodiagnostic studies in the absence of red flags only after failure of 3-4 weeks of conservative treatment. Within the documentation available for review, there are no red flags noted, there is documentation that no treatment had been previously rendered, and conservative treatment in the form of physical therapy and medication was concurrently recommended at the time of this current request. In light of the above issues, the currently requested NCV left upper extremity is not medically necessary.

Omeprazole 20mg Qty 30.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68-69 and 127.

Decision rationale: Regarding the request for Omeprazole, Chronic Pain Medical Treatment Guidelines, states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAIDs (non-steroidal anti-inflammatory drugs) therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested Omeprazole is not medically necessary.

Orphenadrine ER (extended release) 100mg Qty 60.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 and 127.

Decision rationale: Regarding the request for Orphenadrine, Chronic Pain Medical Treatment Guidelines, supports the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is documentation that no treatment had been previously rendered, and 1st line medication management was concurrently recommended at the time of this current request. Furthermore, this medication is a sedating muscle relaxant and there is no indication that the patient was experiencing an acute exacerbation of her pain. In light of the above issues, the currently requested Orphenadrine is not medically necessary.

Medrox pain relief ointment Qty 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 and 127.

Decision rationale: Regarding the request for Medrox, Chronic Pain Medical Treatment Guidelines, cites that topical NSAIDs ((non-steroidal anti-inflammatory drugs) are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." They also cite that topical capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." Within the documentation available for review, there is documentation that no treatment had been previously rendered, and 1st line medication management was concurrently recommended at the time of this current request. The use of a topical NSAID in addition to an oral NSAID would be redundant, and the criteria for the use of either a topical NSAID or capsaicin cited above have not been met. In light of the above issues, the currently requested Medrox is not medically necessary