

Case Number:	CM13-0068385		
Date Assigned:	01/03/2014	Date of Injury:	02/04/2008
Decision Date:	04/21/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/19/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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/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 47-year-old male who reported an injury on 02/04/2008. The mechanism of injury was not provided. The patient is currently diagnosed with degeneration of cervical intervertebral disc, cervical disc displacement, cervical radiculitis, post-laminectomy syndrome, carpal tunnel syndrome, and other unspecified arthropathy of the shoulder. The patient was seen by [REDACTED] on 10/30/2013. The patient reported persistent neck pain. The patient has been previously treated with physical therapy and anti-inflammatories. The patient has completed x-rays, MRI, EMG/NCS, and a CT scan. Physical examination revealed asymmetry of the neck and shoulders with tilting of the head and neck to the left, tenderness to palpation, restricted cervical spine range of motion, diminished sensation, and 5/5 motor strength. Treatment recommendations at that time included continuation of current medication, an EMG/NCV of bilateral upper extremities, and aquatic therapy twice per week for 3 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAM (EMG) OF THE BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back.

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

Decision rationale: California MTUS/ACOEM Practice Guidelines state electromyography and nerve conduction velocities may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms lasting more than 3 or 4 weeks. As per the documentation submitted, the patient's physical examination revealed 5/5 motor strength in bilateral upper extremities. There is no documentation of an exhaustion of conservative treatment. It is also noted that the patient has previously undergone an EMG/NCS. However, the previous report was not submitted for review. There is no documentation of a significant change or progression of the patient's symptoms or physical examination findings that would warrant the need for a repeat study. The medical necessity for the requested service has not been established. Therefore, the request is non-certified.

NERVE CONDUCTION VELOCITY (NCV) OF THE BILATERAL UPPER EXTREMITIES: 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): 177-179.

Decision rationale: California MTUS/ACOEM Practice Guidelines state electromyography and nerve conduction velocities may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms lasting more than 3 or 4 weeks. As per the documentation submitted, the patient's physical examination revealed 5/5 motor strength in bilateral upper extremities. There is no documentation of an exhaustion of conservative treatment. It is also noted that the patient has previously undergone an EMG/NCS. However, the previous report was not submitted for review. There is no documentation of a significant change or progression of the patient's symptoms or physical examination findings that would warrant the need for a repeat study. The medical necessity for the requested service has not been established. Therefore, the request is non-certified.

AQUATIC THERAPY, TWO (2) TIMES A WEEK FOR THREE (3) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: California MTUS Guidelines state aquatic therapy is recommended as an optional form of exercise therapy, where available as an alternative to land based physical therapy. As per the documentation submitted, the patient has previously participated in a course of physical therapy. There is no indication that this patient requires reduced weight-bearing as

opposed to land based physical therapy. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.

PRILOSEC 20MG, #60 (30 DAY SUPPLY): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.

ALPRAZOLAM 1MG, #30 (30 DAY SUPPLY): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: California MTUS Guidelines state benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit the use to 4 weeks. As per the documentation submitted, the patient has continuously utilized this medication. However, there is no documentation of psychiatric symptoms or anxiety disorder. The medical necessity for the ongoing use of this medication has not been established. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. As such, the request is non-certified.