

Case Number:	CM14-0000526		
Date Assigned:	01/10/2014	Date of Injury:	03/22/2013
Decision Date:	06/19/2014	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	01/02/2014

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 and Rehabilitation 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 injured worker is a 54-year-old female who sustained an injury to her bilateral shoulders on 03/22/13. The mechanism of injury was not documented. The injured worker complained of neck pain that radiated towards her bilateral upper extremities associated with on/off numbness and tingling sensation. An electrodiagnostic (electromyography (EMG)/ NCV (nerve conduction velocity) study was performed on 08/22/13 and revealed normal findings. Physical examination of the cervical spine noted tenderness over the paravertebral musculature and over the trapezius muscles; range of motion limited in all planes; compression test positive. An in-home interferential unit to assist with pain and spasm was requested. The injured worker was prescribed Lidoderm Patch, placed on temporary total disability and ultrasound-guided injections to the bilateral shoulders were requested on the basis that the MRI (magnetic resonance imaging) revealed subacromial impingement.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL SHOULDER SA ULTRASOUND GUIDED INJECTIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER CHAPTER, STEROID INJECTIONS.

Decision rationale: The previous request was denied on the basis that that the information submitted did not reflect any extenuating circumstances that would indicate the need for ultrasound guidance. The Official Disability Guidelines (ODG) states that there must be documentation that the injured worker's pain has not been controlled adequately by recommended conservative treatments to include physical therapy and exercise, non-steroidal anti-inflammatory drugs (NSAIDs) or acetaminophen after at least three months. There was no indication of the amount of physical therapy visits the patient has completed to date or the injured worker's response to any previous conservative treatment. Given the clinical documentation submitted for review and in concurrence with the previous denial, medical necessity of the request for bilateral shoulder SA ultrasound-guided injections has not been established. The recommended is for non-certification.

ZANAFLEX 4 MG #90 ONE PO TID: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-67.

Decision rationale: The chronic use of muscle relaxers is not recommended by the MTUS guidelines. At most, muscle relaxers are recommended for short term use only. The efficacy of chronic muscle relaxer use is not established in the clinical literature. There is no indication from the clinical reports that there had been any recent exacerbation of chronic pain or any evidence of a recent acute injury. Based on the clinical documentation provided for review and MTUS guidelines recommendations, the medical necessity of this medication is not established. As such, the request is not certified.

LIDODERM PATCH 5%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM Page(s): 56-57.

Decision rationale: The clinical documentation provided for review did not indicate there were any objective findings regarding a persistent neurological condition contributing to peripheral neuropathic symptoms that would meet the indications for use of a Lidoderm Patch as indicated by the MTUS guidelines. Electrodiagnostic studies were normal and there was no clear indication that the patient had failed a trial of first line medications for neuropathic pain such as anticonvulsants or anti-depressants. Based on the clinical documentation provided for review

and MTUS guidelines recommendations, the medical necessity of this medication is not established. As such, the request is not certified.