MAXIMUS Federal Services

Case Number:	CM14-0010000		
Date Assigned:	02/21/2014	Date of Injury:	11/06/2012
Decision Date:	07/31/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	01/24/2014

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 Occupational Medicine 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 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 33-year-old female who has filed a claim for cervical, thoracic, and shoulder strain associated with an industrial injury date of November 06, 2012. A review of progress notes indicates left hand numbness at night, constant neck pain, headaches, and left shoulder pain. Findings include tenderness over the neck and shoulder musculature, and positive left shoulder impingement sign. MRI of the cervical spine dated April 08, 2013 showed C5-6 and C6-7 herniated nucleus pulposus. Electrodiagnostic testing of the left upper extremity dated April 25, 2013 was normal. MRI of the left shoulder dated November 27, 2013 showed no rotator cuff or labral tear, and lateral downsloping acromion narrowing the supraspinatus outlet with minimal inflammation of the subacromial subdeltoid bursa. Patient is currently performing modified work. The treatment to date has included physical therapy, trigger point injections, Lidoderm patches, subacromial steroid injections to the left shoulder, chiropractic therapy, home exercise program, NSAIDs, opioids, and antidepressants. Utilization review from January 15, 2014 denied the requests for EMG/NCS of the upper extremity as the current findings do not point to a dermatomal or myotomal distribution; and 8 chiropractic treatments as there was no documentation of improvement with previous sessions. There was modified certification for Anaprox 550mg for #90, and acupuncture for 2x3.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG LEFT ARM: 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 10 Elbow Disorders (Revised 2007) Page(s): 238.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back chapter, Electromyography (EMG).

Decision rationale: California MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. ODG states that electromyography findings may not be predictive of surgical outcome and cervical surgery, and patients may still benefit from surgery even in the absence of EMG findings of nerve root impingement. EMG may be helpful for patients with double crush phenomenon, possible metabolic pathology such as with diabetes or thyroid disease, or evidence of peripheral compression such as carpal tunnel syndrome. In this case, the patient has had previous EMG/NCS of the upper extremity in April 2013 showing normal results, when the patient complained of similar symptoms of left forearm numbness and tingling of the fingers. The patient currently does not present with other symptoms or findings of radiculopathy or neuropathy. There is no indication for a repeat electrodiagnostic study as there were no significant changes since the previous study. Therefore, the request for EMG left arm was not medically necessary.

ANAPROX 550 MG BID #100;12 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22 & 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (nonsteroidal anti-inflammatory drugs) Page(s): 67-6..

Decision rationale: As stated on pages 67-69 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. Patient has been on this medication since July 2013. The patient has been able to return to work with modified duties after physical therapy and with medications. Although it is reasonable to continue this medication, the requested quantity of 100 exceeds the dosing schedule of twice a day, and the request for additional months is not indicated without documentation of continued benefits. Therefore, the request for Anaprox 550mg #100 x 12 refills was not medically necessary.

CHIROPRACTIC 2X4 FOR LEFT SHOULDER/NECK: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Manipulation.

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines state that the goal of manual therapy is to achieve positive symptomatic or objective measurable functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. According to ODG, the recommended number of visits for sprains and strains of shoulder and upper arm is 9 visits over 8 weeks. The patient reports increased tolerance for physical activities and decreased pain from the 8 initial chiropractic sessions, and has been instructed on home exercises. The patient is currently performing home exercises, and there is no indication as to why an additional course of chiropractic sessions is necessary. Therefore, the request for chiropractic 2x4 for left shoulder / neck was not medically necessary.

ACUPUNCTURE X10: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function chapter, page 114.

Decision rationale: As noted on page 114 of the California MTUS ACOEM Guidelines, they stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. In addition, Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Functional improvement should be observed within 3-6 treatments, with treatments rendered 1 to 3 times per week and an optimum duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. In this case, there is no documentation as to the functional goals, or regarding intolerance to or reduction in pain medications. Also, the requested number of sessions exceeds guideline recommendations, and the specific body part to which these sessions are directed is not indicated. Therefore, the request for acupuncture x 10 was not medically necessary.

NCS LEFT ARM: 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 10 Elbow Disorders (Revised 2007) Page(s): 238.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back chapter, Nerve conduction studies (NCS).

Decision rationale: California MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. ODG states that nerve conduction studies are not recommended to demonstrate radiculopathy if it has already been clearly identified by EMG and obvious clinical signs. It is recommended if EMG does not show clear radiculopathy, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if the diagnosis may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when symptoms are presumed to be due to radiculopathy. In this case, the patient has had previous EMG/NCS of the upper extremity in April 2013 showing normal results, when the patient complained of similar symptoms of left forearm numbness and tingling of the fingers. The patient currently does not present with other symptoms or findings of radiculopathy or neuropathy. There is no indication for a repeat electrodiagnostic study as there were no significant changes since the previous study. Therefore, the request for NCS of left arm was not medically necessary.