MAXIMUS Federal Services

Case Number:	CM14-0023550		
Date Assigned:	06/11/2014	Date of Injury:	01/29/2010
Decision Date:	09/26/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/25/2014

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 Family 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:

This is a 60-year-old male patient who reported an industrial injury to the shoulders on 4/29/2010, over four (4) years ago, attributed to the performance of his customary job duties. The patient complained of persistent bilateral shoulder pain that occurred intermittently. The patient also complained of numbness and tingling to the bilateral upper extremities. The EMG/NCV dated 1/4/2014, documented evidence of findings are most consistent with bilateral peripheral neuropathy mild and likely related to his diabetes with superimposed moderate carpal tunnel syndrome bilaterally. There was also a delay of sensory peak latency across the wrist on ulnar testing. Mild concurrence cervical radiculopathy cannot be ruled out. The patient was noted be status post left shoulder arthroscopy on 3/20/2011, and right shoulder arthroscopy on 8/9/2010. The objective findings on examination included bilateral shoulders show full range of motion and well-heeled arthroscopic portals with positive cross arm test. The assessment was industrial injury of 1/21/2010, involving bilateral shoulders; status post right shoulder arthroscopy on 8/9/2010; catalog to the left shoulder on 12/20/2010, and December 26, 2012; status post left shoulder arthroscopy on 3/28/2011; bilateral shoulder MRI on 4/27/2012 which showed no recurrent tear with postoperative changes and rotator cuff tendinitis; status post bilateral shoulder Kenalog injection on 5/29/2013. The treatment plan included in tenured ice; NSAIDs; self-directed home exercise program; and regular work.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PAIN MANAGEMENT EVALUATION AND TREATMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2ndEdition, (2004) chapter 6 page 127.

Decision rationale: The request for authorization of the pain management for evaluation and treatment is not supported with objective evidence to support the medical necessity of the request. The patient was noted to have bilateral shoulder pain status post bilateral shoulder arthroscopy and rehabilitation PT. The treating physician documented functional improvement with treatment. There was a request for pain management evaluation and treatment. There is no clear documentation of objective findings requiring more treatment other than the recommended home exercise program for conditioning and strengthening. The patient should be treated with OTC medications and HEP. The medical record provides no objective findings to the right shoulder postoperatively other than TTP with FROM to support the medical necessity of the requested pain management. There is no provided rationale to support the medical necessity of an evaluation and treatment with pain management. There is no objective evidence to support the medical necessity of the referral to a pain management for additional treatment in relation to the diagnosed chronic bilateral post-operative shoulder pain. There is no medical necessity for interventional pain management to the postoperative shoulder and lower back. The medical necessity of a pain management for an evaluation and treatment is not demonstrated as there is no objective evidence of any further treatment being required other than conservative care and home exercises.

1 EMG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 261;303, 301, 298; 48; 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back--electromyography; Carpal tunnel syndrome--EDS.

Decision rationale: The patient was noted to complain of worsening pain to the neck and left upper extremity. There were no complaints or neurological deficits documented for the right/left upper extremity. The patient was requested to have an EMG of the right/left upper extremity directed to the diagnosis of neck and BUE pain. There is no documentation of any neurological deficits to the BUE. The objective findings on examination as documented were limited to the tenderness with palpation and no demonstrated neurological deficits to the BUE. There were no complaints to the BUE other than subjective complaints and there were no documented objective findings to the BUE that included sensory or motor deficits. There were no peripheral

neurological findings or motor/sensory deficits along a dermatomal distribution that would meet the criteria for the authorization of Electrodiagnostic studies of the RUE for an evaluation of a nerve compression neuropathy or radiculopathy. The EMG of the BUEs was ordered as a screening test. The request for the authorization of the EMG of the right/left upper extremity was not supported with any objective clinical findings that demonstrate a neurological deficit or change in neurological status to the BUE in relation to the DOI.

1 NCV: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 261;303, 301, 298; 48; 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back--electromyography; Carpal tunnel syndrome--EDS.

Decision rationale: The patient was noted to complain of worsening pain to the neck and left/right upper extremity. There were no complaints or neurological deficits documented for the right/left upper extremity. The patient was requested to have an NCV of the right/left upper extremity directed to the diagnosis of increased neck and BUE pain. There is no documentation of any neurological deficits to the RUE. There were no noted neurological deficits to the BUE in addition to the reported objective findings on examination. The objective findings on examination as documented were limited to the tenderness with palpation and no demonstrated neurological deficits to the BUE. There were no complaints to the BUE other than subjective complaints and there were no documented objective findings to the BUE that included sensory or motor deficits. There were no peripheral neurological findings or motor/sensory deficits along a dermatomal distribution that would meet the criteria for the authorization of Electrodiagnostic studies of the BUE for an evaluation of a nerve compression neuropathy or radiculopathy. The NCV of the BUEs was ordered as a screening test. The request for the authorization of the NCV of the right/left upper extremity was not supported with any objective clinical findings that demonstrate a neurological deficit or change in neurological status to the BUE in relation to the DOI. There is no demonstrated medical necessity for a NCV of the right/left upper extremity.

VOLTAREN GEL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; NSAIDs Page(s): 111-113; 22, 67-68, 71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter topical analgesics; NSAIDs and Other Medical Treatment Guidelines American College of Occupational and Environmental Medicine (ACOEM), 2ndEdition, (2004) Chapter 6 pages 114-15.

Decision rationale: The topical NSAID, Voltaren 1% gel, is not medically necessary in addition to prescribed oral NSAIDs. The patient has been prescribed topical Voltaren gel for chronic neck pain post operatively. The patient has received topical NSAID gels for a prolonged period of time exceeding the time period recommended by evidence-based guidelines. There is no demonstrated medical necessity for both an oral NSAID and a topical NSAID. There is no provided subjective or objective evidence that the patient has failed or not responded to other conventional and recommended forms of treatment for relief of the effects of the industrial injury. Only if the subjective/objective findings are consistent with the recommendations of the CA MTUS, then topical use of topical preparations is only recommended for short-term use for specific orthopedic diagnoses. There is no documented functional improvement by the provider attributed to the topical NSAID.The use of topical NSAIDS is documented to have efficacy for only 2-4 weeks subsequent to injury and thereafter is not demonstrated to be as effective as oral NSAIDs. There is less ability to control serum levels and dosing with the topicals. The patient is not demonstrated to have any GI issue at all with NSAIDS. The patient was prescribed an oral opioids and topical NSAID concurrently. The use of the topical creams/gels does not provide the appropriate therapeutic serum levels of medications due to the inaccurate dosing performed by rubbing variable amounts of creams on areas that are not precise. The volume applied and the times per day that the creams are applied are variable and do not provide consistent serum levels consistent with effective treatment. There is no medical necessity for the addition of creams to the oral medications in the same drug classes. There is no demonstrated evidence that the topicals are more effective than generic oral medications.The prolonged use of topical Voltaren gel 1% not supported by the applicable evidence-based guidelines. The continued use of topical NSAIDs for the current clinical conditions is not otherwise warranted or demonstrated to be medically necessary. The prescribed topical Voltaren topical cream or gel is not demonstrated be medically necessary.