

Case Number:	CM14-0069253		
Date Assigned:	07/14/2014	Date of Injury:	04/12/2011
Decision Date:	09/18/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/14/2014

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 Anesthesiology, has a subspecialty in Pain 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 injured worker is a 63-year old male who had a work related injury on 04/12/11. Mechanism of injury was not documented. The injured worker underwent arthroscopic surgery of his right shoulder in 04/11, and then had revision in 05/13 with acromioplasty decompression, and debridement. Magnetic resonance image of the cervical spine dated 03/23/12, at C3-4 showed severe left neural foraminal stenosis, moderate right stenosis, mild cord compression, no cord signal changes. C4-5 central canal stenosis, mild cord compression, no cord signal changes, severe right neural foraminal stenosis and moderate left neural foraminal stenosis. C5-6 moderate severe neural foraminal stenosis left greater than right. C6-7 moderately severe stenosis left greater than right. The injured worker also had physical therapy, trigger point injections, anti-inflammatory medications. Most recent clinical documentation submitted for review was dated 04/23/14. The injured worker was seen for an established follow up in the office today. He still continued to complain of cervical and right arm and shoulder pain. Physical examination well developed, well nourished. Affect was normal and positive. In no acute distress. Musculoskeletal exam, shoulder girdle, no erythema, ecchymosis, or edema. Moderate tenderness over the right supraclavicular area. Head and neck in neutral position. Movement mildly restricted in all directions, movement mild moderately restricted in all directions, pain elicited in all directions. Normal stability, normal strength and tone. Right upper extremity, generalized severe tenderness over the right shoulder girdle. Strength of the major groups was 4/5 on the right side. 5/5 on the left. No fasciculations. Muscle spasms in the right scalene was positive. Posture was altered due to right shoulder depression, internal rotation of the right shoulder. Positive Adson's maneuver on the right. Assessment; right brachio plexus lesions. Arthropathy right shoulder region. Cervicalgia. Prior utilization review on 05/06/14 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram Right Upper Extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: The request for Electromyogram Right Upper Extremity is medically necessary. The clinical information submitted for review as well as current evidence based guidelines support the request. The injured worker is 4 years status post injury, continues to have symptoms, including weakness in right upper extremity, does not correlate with the imaging studies. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Therefore, Electromyogram Right Upper Extremity is medically necessary.

Nerve Conduction Studies of Right Upper Extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: clinical information submitted for review as well as current evidence based guidelines support the request. The injured worker is 4 years status post injury, continues to have symptoms, including weakness in right upper extremity, does not correlate with the imaging studies. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Therefore, Nerve Conduction Studies of Right Upper Extremity is medically necessary.

MRI Right Plexus: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

Decision rationale: The request for magnetic resonance image of the right brachial plexus is medically necessary. The clinical documents submitted for review does supports the request. The physical examination show 4/5 strength in right upper extremity, and positive Adson's test on the right. The injured worker has been symptomatically greater than 1 year. medical necessity has not been established. As such, MRI Right Plexus is medically necessary.

PT 2-3X6: Overturned

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

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, Physical therapy.

Decision rationale: The request for physical therapy (PT) 2-3X6 is medically necessary. There is no clinical evidence submitted that shows that the injured worker has had previous PT for this diagnosis. The curent evidence based guidelines recommend; Brachial plexus lesions (Thoracic outlet syndrome) Medical treatment: 14 visits over 6 weeks. Post-surgical treatment: 20 visits over 10 weeks. Therefore, Physical Therapy 2-3X6 is medically necessary.

Multidisciplinary Pain Management Program: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Chronic pain programs (functional restoration programs) Criteria for the general use of multidisciplinary pain management programs.

Decision rationale: The medical records reviewed does not meet the criteria per Official Disability Guidelines. (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors; (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function. Therefore, Multidisciplinary Pain Management Program is not medically necessary.