

Case Number:	CM14-0204058		
Date Assigned:	12/16/2014	Date of Injury:	07/02/2013
Decision Date:	02/10/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/05/2014

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 Rehabilitation 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 50-year old female with date of injury 7/2/13. The treating physician report dated 10/29/14 (196) indicates that the patient presents with pain affecting her neck and bilateral shoulders, left worse than right. Pain level is recorded as 8/10 without medication and 6.5-7/10 with medication. The physical examination findings reveal there is stiffness and tightness on the left side of the cervical paravertebrals. Cervical range of motion is decreased. There is tenderness of the left acromioclavicular joint and subacrominal space. Left shoulder range of motion is restricted and painful. Neer's and Hawkins are positive on the left side. There's tenderness in the left lateral condyle. Prior treatment history includes acupuncture, physical therapy and use of Tylenol #3. MRI findings dated 6/20/14 (99) reveal moderate narrowing C5-6 intervertebral disc with minimal posterior bony endplate proliferation. No resultant segmental stenosis is evident at this level. There is mild left foraminal narrowing at this level. The findings noted C5-6 there is moderate narrowing of the intervertebral disc and minimal posterior bony endplate proliferation. There is significant right foraminal encroachment and mild left foraminal narrowing seen in association. The current diagnoses are: - Cervical strain- Left shoulder sprain- Left elbow sprain-Left wrist sprain - Cervical disc disease The utilization review report dated 11/20/14 (9) modified the request for Physical Therapy 2 times/week for 4 weeks for left shoulder and neck to allow 2 sessions based upon MTUS. The utilization review report additionally denied the request for Tylenol #3, 1 orally every 8 hours as needed for severe pain, #90 based on MTUS, denied the request for NCV/EMG left upper extremity based on ACOEM pages 177-178, 261, 309 and ODG, finally the utilization review report denied the request for Urine Toxicology Screen based on MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 times/week for 4 weeks for left shoulder and neck: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The patient presents with pain affecting her neck and bilateral shoulders, left worse than right. The current request is for Physical Therapy 2 times/week for 4 weeks for left shoulder and neck. The treating physician report dated 10/29/14 (196) states, "Patient should benefit of acupuncture, physical therapy and/or chiropractic treatment, which are all available through the DWC. Additionally the report notes, the request for physical therapy for increasing range of motion, decreasing pain and increasing functional capacity." The MTUS guidelines recommend 8-10 sessions for myalgia and neuritis type conditions. In this case, the QME report dated 8/14/14 (220) documents that the patient has received "12 session of physical therapy without benefit." The MTUS guidelines recommend 8-10 and the patient has already received 12 sessions. There is no documentation of a new injury or diagnosis to support this request and it is not medically necessary. Therefore, recommendation is for denial.

Tylenol #3, 1 orally every 8 hours as needed for severe pain, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74, 88-89.

Decision rationale: The patient presents with pain affecting her neck and bilateral shoulders, left worse than right. The current request is for Tylenol #3, 1 orally every 8 hours as needed for severe pain, #90. The treating physician report dated 10/29/14 (196) states, "I am refilling her Tylenol No 3 ... as needed for sever pain." Tylenol #3 (acetaminophen and codeine) is classified by MTUS, pure-agonists; which include natural and synthetic opioids. For chronic opiate use, MTUS Guidelines state, "pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the medical records provided have not documented the 4 As as required by the MTUS guidelines. There is no discussion of before and after pain scales; there is no documentation of any functional benefit from opioid usage. The MTUS guidelines require much more thorough documentation for continued usage. The current request is not medically necessary and therefore, recommendation is for denial and slow weaning per MTUS.

NCV/EMG left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 177-178, 261, 309, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back Chapter, Electrodiagnostic studies (EDS)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) < Neck & Upper Back>, <Electromyography (EMG) and Nerve conduction studies (NCS)>.

Decision rationale: The patient presents with pain affecting her neck and bilateral shoulders, left worse than right. The current request is for NCV/EMG left upper extremity. The treating physician report dated 10/29/14 (196) states, "NCV/EMG of upper extremities should be performed in order to complete the diagnostic workup". ODG state, EMG recommended as an option in selected cases. If the physician has documented radiating pain into the extremity, and the physician requires differentiation of carpal tunnel syndrome vs. cervical radiculopathy or double crush syndrome, then an EMG of the upper extremity is medically necessary. If there is neck or arm symptoms or both lasting longer than 3-4 weeks then it is medically necessary. Here, we find there is no documentation of radiating pain in the extremity nor do the records indicate the physician is attempting to differentiate between carpal tunnel syndrome vs. cervical radiculopathy or double crush syndrome. ODG defines NCV as a form of NCS. Regarding NCS, ODG states, not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. Here, we find the records provided fail to provide the required level of documentation of the patient's status regarding radiculopathy. Therefore, recommendation is for denial.

Urine Toxicology Screen: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Urine drug testing (UDT).

Decision rationale: The patient presents with pain affecting her neck and bilateral shoulders, left worse than right. The current request is for Urine Toxicology Screen. The treating physician report dated 10/29/14 (196) states, "As per our office policy, we perform the random and routine urine screening test on patient who are on the narcotics and/or other drugs." ODG states that the "frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument." In this case the treating physician records have not documented the patient's risk stratification, which would dictate the patient's risk level and in turn the frequency with which testing should be done. There is documentation that the patient has already received a UDS on 5/22/14 and since the patient has no documented moderate or high

risk factors of opioid abuse additional screening is not medically necessary more than once per year. Recommendation is for denial.