

Case Number:	CM15-0200329		
Date Assigned:	10/15/2015	Date of Injury:	07/09/2015
Decision Date:	11/24/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/13/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Anesthesiology

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 58 year old female, who sustained an industrial injury on 7-9-2015. The injured worker is undergoing treatment for: cumulative trauma of the neck, right shoulder, right upper extremity, psychological, sleep disturbance, and internal symptoms. On 9-22-2015, she indicated reporting multiple work related injuries since 2000. She reported neck pain and radiation into the right shoulder, right scapular and upper back, with numbness and tingling in the right hand and fingers. She also reported bilateral hip pain that is increased with prolonged activities. She indicated having sleeping difficulty, awakening with pain, and gastrointestinal issues. She indicated having difficulty with activities of daily living such as showering and dressing. Physical findings revealed an uneven gait, tenderness, spasm and restricted range of motion in the neck, tenderness and restricted range of motion to the bilateral shoulders, positive impingement sign on the right. The treatment and diagnostic testing to date has included: injection of the right shoulder (4-16-15), medications, x-ray and magnetic resonance imaging of the right shoulder (4-16-15), bilateral hip surgery (dates unclear). Medications have included: Norco, omeprazole, Temazepam, metformin, glipizide, insulin injection u100, crestor, aspirin, and losartan. Current work status: not working since date of injury. The request for authorization is for: Physical therapy x24 for the cervical spine, physical therapy x24 for the right shoulder, EMG-NCV of bilateral upper extremities, magnetic resonance imaging of the cervical spine, Ketoprofen ER 200mg one capsule daily as needed quantity 30 with 2 refills, Omeprazole DR 20mg one capsule daily quantity 30 with 2 refills. The UR dated 10-6-2015: non-certified the requests for Physical therapy x24 for the cervical spine, physical therapy x24 for the right shoulder, EMG-NCV of bilateral upper extremities, magnetic resonance imaging

of the cervical spine, Ketoprofen ER 200mg one capsule daily as needed quantity 30 with 2 refills, Omeprazole DR 20mg one capsule daily quantity 30 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x 24 for the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Physical Examination.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of neck pain. The ODG recommends that for most patients with more severe and sub-acute neck pain conditions, up to 10 visits are indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, the requested number of physical therapy sessions (24) exceeds the guideline recommendations. Medical necessity for the requested services has not been established. The requested services are not medically necessary.

Physical therapy x24 for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of shoulder pain. The ODG recommends that for most patients with shoulder pain, up to 10 visits are indicated as long as functional improvement and program progression are documented; and up to 30 visits over 18 weeks for post-surgical open treatment. For rotator cuff disorders, physical therapy can improve short-term recovery and long-term function. For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopedic referral. Patients with small tears of the rotator cuff may be referred to an orthopedist after 6 to 12 weeks of conservative treatment.

Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, the requested number of physical therapy sessions (24) exceeds the guideline recommendations. Medical necessity for the requested services has not been established. The requested services are not medically necessary.

EMG/NCV of bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve Conduction Velocity Testing (NCV).

Decision rationale: The request for diagnostic testing EMG/NCV for bilateral upper extremities is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. The ODG further states that nerve conduction studies are 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. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. In this case, there are no findings of neurological deficits or any documentation indicating that the injured worker had failed conservative care treatments. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.

MRI of cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI of the cervical spine.

Decision rationale: According to CA MTUS/ACOEM guidelines, a cervical MRI is indicated if unequivocal findings identify specific nerve compromise on the neurologic examination, in patients who do not respond to conservative treatment, and who would consider surgical intervention. Cervical MRI is the mainstay in the evaluation of myelopathy. Per the ODG, an MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. In this case, there are no new neurologic findings on physical exam to

warrant a MRI study. In addition, there is no documentation of completion a full course of conservative treatment. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Ketoprofen ER 200mg, 1 capsule daily as needed, #30 refill x2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Ketoprofen is a non-steroidal anti-inflammatory drug (NSAID). According to the CA MTUS Guidelines (2009), oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. In this case, the patient has been on previous long-term NSAIDs without any documentation of significant improvement. Medical necessity for the requested medication has been established. The requested NSAID is not medically necessary.

Omeprazole Dr 20mg capsule, 1 cap daily #30 refill x2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. In this case, the NSAID was not medically necessary. Based on the available information provided for review, the medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.