MAXIMUS Federal Services

Case Number:	CM15-0203266		
Date Assigned:	10/20/2015	Date of Injury:	10/19/2002
Decision Date:	12/29/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	10/15/2015

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: California, Texas, Florida
Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

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 44 year old female who sustained an industrial injury on 10/19/2002. Medical records indicated the worker was treated for cervical sprain, subacromial bursitis of the right shoulder, and rule out peripheral neuropathy. In the provider notes of 08-04-2015, the injured worker complains of pain in her right shoulder traveling to the upper trapezius. She describes her pain as throbbing and aching and rates it as an 8-9 on a numeric rating scale of 0-10. She also complains of numbness and tingling in the arm. She notes her pain is worsening and she experiences flare ups of her shoulder pain. She also complains of frequent neck pain described as sharp, stabbing and migraines. She rates this pain as a 7 on a scale of 0-10. Pain keeps her awake at night. Fioricet is taken for migraines. Her pain is reduced with rest and activity modifications. Ultram also helps her pain. On examination, palpation reveals non-specific tenderness of the right shoulder and mild tenderness at the upper trapezius. Impingement maneuver and Codman drop arm teat are positive on the right. There are no limitations in range of motion in either shoulder. In the cervical spine C1 through C7, palpation reveals mild paraspinal tenderness, muscle guarding and spasms bilaterally. Palpation also reveals mild tenderness at the bilateral facet joints at that level referring to the neck and trapezius. The plan is for medications and electrodiagnostic studies plus radiologic studies. A request for authorization was submitted for 1. Norco 10/325mg #120, 2. Electromyograph (EMG) and nerve conduction velocity (NCV) of the right shoulder, 3. MRI CT ordered, review requested for the right shoulder, 4. Fioricet #120 with 1 refill. 5. Restoril 15mg #45 with 2 refills. A utilization review decision 09/21/2015 non-certified Electromyograph (EMG) and

nerve conduction velocity (NCV) of the right shoulder, MRI CT ordered, review requested for the right shoulder, Fioricet #120 with 1 refill, Restoril 15mg #45 with 2 refills. Certified Norco 10/325mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyograph (EMG) and nerve conduction velocity (NCV) of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): General Approach, Initial Assessment, Medical History, Physical Examination, Diagnostic Criteria, Initial Care, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies.

Decision rationale: Regarding the request for Electromyograph (EMG) and nerve conduction velocity (NCV) of the right shoulder, Occupational Medicine Practice Guidelines state that the electromyography and nerve conduction velocities 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. Guidelines go on to state that EMG is recommended to clarify nerve root dysfunction if findings of history and physical exam are consistent. Within the documentation available for review, there are no recent subjective complaints or physical examination findings identifying subtle focal neurologic deficits in a radicular distribution. In the absence of such documentation, the currently requested Electromyograph (EMG) and nerve conduction velocity (NCV) of the right shoulder is not medically necessary.

MRI CT ordered, review requested for the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Computed tomography.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): General Approach, Initial Assessment, Medical History, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI); Shoulder Complaints, Computed tomography (CT).

Decision rationale: Regarding the request for MRI CT ordered, review requested for the right shoulder, Occupational Medicine Practice Guidelines state that the primary criteria for ordering imaging studies are the emergence of a red flag, physiologic evidence of a tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid

surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends CT scan after x-ray for suspected labral tear and full thickness rotator cuff tear. Occupational Medicine Practice Guidelines state that more specialized imaging studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Within the documentation available for review, there is no documentation that the patient has failed conservative treatment options or has had plain film radiographs. Additionally, there is no statement indicating how the patient's management will be changed depending upon the outcome of the currently requested CT. Furthermore, it is unclear how an MRI will change the patient's current treatment plan. Finally, the physician states that he wants an updated study, however repeat MRI are not routinely recommended and there is no documentation of a significant change from the prior study, if it was done before. In the absence of clarity regarding those issues, the currently requested MRI CT ordered, review requested for the right shoulder is not medically necessary.

Fioricet #120 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Barbiturate-containing analgesic agents.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Barbiturate-containing analgesic agents.

Decision rationale: Regarding the request for Fioricet, Chronic Pain Medical Treatment Guidelines state that barbiturate containing analgesic agents are not recommended for chronic pain. They go on to state that the potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. As such, the currently requested Fioricet #120 with 1 refill is not medically necessary.

Restoril 15mg #45 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

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

Decision rationale: Regarding the request for Restoril 15mg #45 with 2 refills, Chronic Pain Medical Treatment Guidelines state the benzodiazepines are "Not recommended for long-term

use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an anti-depressant." ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no description of failure of behavioral treatment, response to medication, etc. As such, there is no clear indication for use of this medication. Finally, there is no indication that Restoril is being used for short term use as recommended by guidelines. In light of the above issues, the currently requested Restoril 15mg #45 with 2 refills is not medically necessary.