

Case Number:	CM15-0042001		
Date Assigned:	03/24/2015	Date of Injury:	12/22/2009
Decision Date:	05/12/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/05/2015

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

Certification(s)/Specialty: Orthopedic Surgery, Sports 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 60-year-old female who reported an injury on 12/22/2009. The mechanism of injury was not provided. Her diagnoses were noted as cervical discopathy, C5-6 disc herniation, lumbar discopathy, and left shoulder rotator cuff syndrome and impingement. During the assessment on 02/06/2015, the injured worker complained of ongoing pain to her bilateral shoulders and bilateral hands. She also reported ongoing low back pain as well. The physical examination of the right shoulder revealed tenderness to the acromioclavicular joint and trapezius muscle on the right side with spasm. There was loss of range of motion with forward flexion to approximately 145 degrees and 120 degrees abduction. The physical examination of the left shoulder revealed acromioclavicular joint tenderness. There was crepitus with motion and pain on range of motion, which was limited to approximately 120 degrees in forward flexion and 100 degrees in abduction. The physical examination of the bilateral wrists revealed a positive Tinel's and Phalen's sign. There was decreased median nerve sensation as well as decreased grip strength. There was painful radiating pain to the extensor muscles. The physical examination of the right hip revealed pain and difficulty with rotation internally with extension just past the greater trochanter of the right hip. The treatment plan was to continue with further treatment and care. The rationale for the request was to confirm carpal tunnel in the bilateral upper extremities. The Request for Authorization form was dated 02/06/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): table 8-8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The request for EMG/NCV of the bilateral upper extremities is not medically necessary. The California MTUS/ACOEM Guidelines state electrical studies may be indicated for patients with findings consistent with peripheral nerve impingement or symptoms persistent despite 4 to 6 weeks of conservative care. The physical examination of the bilateral wrists revealed positive Tinel's and Phalen's signs with decreased median nerve sensation. However, there was no documentation that the patient had failed 4 to 6 weeks of conservative treatment prior to the requested electrodiagnostic testing. Furthermore, the prior electromyography testing was noted as normal and did not rule out radiculopathy prior to the request for the nerve conduction study. As such, the request is not medically necessary.

Physical therapy for the right shoulder, twice weekly for four weeks: Upheld

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

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

Decision rationale: The request for Physical therapy for the right shoulder, twice weekly for four weeks is not medically necessary. The California MTUS Guidelines recommend up to 10 visits over 8 weeks for myalgia and myositis, unspecified. However, the clinical documentation did not indicate the number of completed physical therapy visits, making it difficult to determine if the request exceeds guideline recommendation. Additionally, there was a lack of adequate information regarding whether or not the injured worker had benefitted from the past physical therapy visits or if there were any functional improvements made. As such, the request is not medically necessary.

Tizandine 4 mg, sixty count with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain) Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The request for Tizandine 4 mg, sixty count with one refill is not medically necessary. The California MTUS Guidelines recommend muscle relaxants as a second line option for short term treatment of acute low back pain, and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time, and there was a lack of documentation of objective improvement. As such, the ongoing use is not supported. Given the above, the request is not medically necessary.

Norco 10/325 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the Use of Opioids Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, on-going management Page(s): 78.

Decision rationale: The request for Norco 10/325 mg, sixty count is not medically necessary. The California MTUS Guidelines state that ongoing management of opioid use should include documentation of pain relief, functional status, side effects, and appropriate medication use with the use of random drug screening as needed to verify compliance. The clinical documentation provided did not include any quantified information regarding pain relief. There was a lack of documentation regarding adverse effects and evidence of consistent results on urine drug screens to verify appropriate medication use. Additionally, the frequency was not provided. As such, the request is not medically necessary.