

Case Number:	CM15-0050010		
Date Assigned:	03/23/2015	Date of Injury:	12/30/2013
Decision Date:	05/12/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/16/2015

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: Physical Medicine & Rehabilitation

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 41-year-old male who reported an injury on 12/30/2013. Request for Authorization submitted for review dated 02/05/2015. The diagnosis was shoulder impingement. The documentation of 02/05/2015 revealed the injured worker had an MRI of the right shoulder which demonstrated rotator cuff tendinosis with infraspinatus tendon and fraying of the articular surface of the distal supraspinatus 1.4 cm, moderate AC joint arthrosis and hypertrophy, large area with multiseptated and multilobulated paralabral cysts anterior inferiorly with thickened synovium associated cyst and possible labral tear was present. The injured worker was approved for surgery; however, had to postpone due to high blood sugar. The documentation indicated the injured worker was status post physical therapy and 2 cortisone injections and the fluoroscopic study of the right shoulder revealed no calcific lesion. The injured worker had neck traction, neck pillow, hot and cold wrap, and TENS unit. The injured worker did not have a back brace. The injured worker was noted to have the medications Percocet 5 mg, Topamax, Keflex, and Zofran at home since surgery was postponed. The physical examination revealed tenderness in the right shoulder, rotator cuff, and bicep tendon. The injured worker had a positive impingement and a Hawkins sign. Abduction was 160 degrees. The treatment plan included a back brace, neck pillow, neck traction, TENS unit, Nalfon 400 mg, Flexeril 7.5 mg, and Norco 5/325 mg. Additionally, the request was made for an EMG of the upper extremities and fluoroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Cervical Pillow: 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) Neck and Upper Back (Acute & Chronic).

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 Chapter, Pillow.

Decision rationale: The Official Disability Guidelines indicate a neck support pillow is appropriate to be used in conjunction with daily exercise. Injured workers with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep. Either strategy alone did not do the desired clinical benefit per the RCT. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. There was a lack of documentation indicating the injured worker would be utilizing the pillow in conjunction with daily exercise. Given the above, the request for 1 cervical pillow is not medically necessary.

1 Cervical Traction with Air Bladder: 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) Neck and Upper Back (Acute & Chronic).

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 Chapter, Traction (mechanical).

Decision rationale: The Official Disability Guidelines indicate that mechanical traction, including cervical patient controlled traction for patients with radicular symptoms, in conjunction with a home exercise program is appropriate. However, there was a lack of documentation indicating the injured worker would utilize the unit in addition/conjunction with a home exercise program. Additionally, the request as submitted failed to indicate whether the unit was for rental or purchase. Given the above, the request for 1 cervical traction with air bladder is not medically necessary.

1 IF or Muscle Stimulator: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices). Interferential Current Stimulation Page(s): 121,118.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention and it should be used with recommended treatments including work, and exercise. The California Medical Treatment Utilization Schedule guidelines do not recommend Neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its use in chronic pain. They do not recommend Interferential Current Stimulation (ICS) as an isolated intervention. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. There was a lack of documentation indicating the injured worker would utilize the unit in conjunction with exercise. There was a lack of clarification indicating whether the unit was a neuromuscular stimulator or an interferential unit. The request as submitted failed to indicate the duration of use and whether the unit was for rental or purchase. Given the above, the request for 1 IF or muscle stimulator is not medically necessary.

Flexeril 7.5mg, #30: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second line option for the 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 is a lack of documentation of objective improvement. There was a lack of documentation of exceptional factors. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Flexeril 7.5 mg #30 is not medically necessary.

Norco 10/325mg, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured

worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain. There was a lack of documentation indicating the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 10/325 mg #120 is not medically necessary.

1 NCS/EMG Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic).

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

Decision rationale: The American College of Occupational and Environmental Medicine states that 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. There should be documentation of 3 to 4 weeks of conservative care and observation. There is no documentation of peripheral neuropathy condition that exists in the bilateral upper extremities. There is no documentation specifically indicating the necessity for both an EMG and NCV. The clinical documentation submitted for review failed to provide documentation of a failure of conservative care. There was a lack of documentation of myotomal and dermatomal findings to support the necessity for EMG and NCV. There was a lack of documentation indicating a necessity for bilateral studies. Given the above, the request for 1 NCS/EMG bilateral upper extremities is not medically necessary.

1 Fluoroscopy upper Extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The American College of Occupational and Environmental Medicine indicates for most patients with shoulder problems, special studies are not needed unless a 4 to 6 weeks period of conservative care and observation fails to improve symptoms. The clinical documentation submitted for review failed to provide documentation of a failure of conservative care and observation. The request as submitted failed to provide rationale for the request. The physician documentation failed to provide documented rationale for the request. Given the above, the request for 1 fluoroscopy of upper extremities is not medically necessary.