MAXIMUS Federal Services

Case Number:	CM15-0080398		
Date Assigned:	05/01/2015	Date of Injury:	03/06/2015
Decision Date:	07/08/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	04/27/2015

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 31-year-old male/female, who sustained an industrial/work injury on 3/6/15. She reported initial complaints of pain and soreness in the shoulders. The injured worker was diagnosed as having cervical strain, rule out herniation; right upper extremity radicular pain/numbness, rule out cervical radiculopathy verses peripheral process; bilateral shoulder rotator cuff syndrome; lumbar disc herniation; and s/p lumbar fusion. Treatment to date has included medication and surgery. Currently, the injured worker complains of frequent pain in both shoulders, (R>L) with inability in lifting the right arm. Per the primary physician's progress report (PR-2) on 3/19/15, the pain increases with rotation, torqueing motion, reaching overhead, lifting, carrying, pushing, and abduction or external rotation. The injured worker noted clicking, popping, and grinding in both shoulders. There is swelling, numbness, tingling, and burning sensation in the right arm. Pain is 7-8/10. Exam revealed walking with a limp favoring the left side, mild limited range of motion to the cervical spine, tenderness and hypertonicity bilaterally to the cervical paravertebral muscles. The lumbar spine had minimal restrictions for range of motion and unable to heel to toe walk. The shoulders had some limited range of motion (R>L), tenderness with palpation of the trapezius and parascapular musculature. The requested treatments include MRI of left shoulder, MRI of right shoulder, EMG/NCS of the bilateral upper extremities, 12 Physical Therapy sessions for bilateral shoulders, and Kera-Tek analgesic gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI of left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter, Magnetic resonance imaging (MRI).

Decision rationale: The patient presents with pain and weakness in his neck, shoulder and upper extremity. The patient is s/p multiple surgeries including lumbar fusion in 2014 and left elbow surgery in 2014. The request is for MRI OF THE LEFT SHOULDER. RFA is not provided. Per 03/25/15 progress report, there is mild tenderness over the left rotator cuff. Per 03/19/15 progress report, Supraspinatus, Neer's and Hawkins impingement tests are positive. Per 03/19/15 progress report, the patient has had an X-ray. The date and the result of X-ray are not provided. Regarding work statue, the patient is currently working. MTUS does not discuss MRI's. ACOEM guidelines page 207-208 do not recommend MRI except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain, cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint or there is failure to progress in a strengthening program intended to avoid surgery. ACOEM guidelines refer to acute/subacute condition. ODG guidelines, under shoulder chapter, Magnetic resonance imaging (MRI) Topic, do not support MRI unless there is a suspicion for internal derangement. In this case, the review of the reports shows that the patient has not had a previous MRI of the left shoulder. The treater requested MRI of the left shoulder to rule out rotator cuff tears. The patient has persistent pain with exam showing positive impingement. ODG supports an MRI to rule out rotator cuff and labral tear issues and the request appears reasonable. The request IS medically necessary.

1 MRI of right shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official disability guidelines Shoulder chapter, Magnetic resonance imaging (MRI).

Decision rationale: The patient presents with pain and weakness in his neck, shoulder and upper extremity. The patient is s/p multiple surgeries including lumbar fusion in 2014 and left elbow surgery in 2014. The request is for MRI OF THE RIGHT SHOULDER. RFA is not provided. Per 03/25/15 progress report, there is mild tenderness over the right rotator cuff. Per 03/19/15 progress report, Supraspinatus, Neer's and Hawkins impingement tests are positive. The patient has had an X-ray. The date of X-ray and the results of X-ray are not provided. Regarding work statue, the patient is currently working. MTUS does not discuss MRI's. ACOEM guidelines page 207-208 do not recommend MRI except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain, cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC

joint or there is failure to progress in a strengthening program intended to avoid surgery. ACOEM guidelines refer to acute/subacute condition. ODG guidelines, under shoulder chapter, Magnetic resonance imaging (MRI) Topic, do not support MRI unless there is a suspicion for internal derangement. In this case, the review of the reports shows that the patient has not had a previous MRI of the right shoulder. The treater requested MRI of the right shoulder to rule out rotator cuff tears. The patient has persistent pain with exam showing positive impingement. ODG supports an MRI to rule out rotator cuff and labral tear issues and the request appears reasonable. The request IS medically necessary.

1 EMG/NCS of the bilateral upper extremities: Overturned

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, Electromyography, Nerve conduction studies.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

Decision rationale: The patient presents with pain and weakness in his neck, shoulder and upper extremity. The patient is s/p multiple surgeries including lumbar fusion in 2014 and left elbow surgery in 2014. The request is for EMG/NCV OF BILATERAL UPPER EXTREMITY. RFA is not provided. Per 03/25/15 progress report, "The patient describes numbness and/or tingling at shoulder or upper extremity. " Per 03/19/15 progress report, cervical compression test, Spurling's test and shoulder decompression test, Supraspinatus, Neer's and Hawkins impingement tests are positive. Regarding work statue, the patient is currently working. The ACOEM guidelines page 262 on EMG/NCV states that appropriate studies (EDS) may help differentiate between CTS and other condition such as cervical radiculopathy. In addition, ODG states that electrodiagnostic testing includes testing for nerve conduction velocities (NCV) and possibly the addition of electromyography (EMG). Electromyography and nerve conduction velocities including H- reflex test may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms or both, lasting more than 3 or 4 weeks. ACOEM guidelines Ch11 page 262 states that "tests may be repeated later in the course of treatment if symptoms persist." In this case, there is no documentation that patient has had prior EMG/NCV studies. The patient has kept reporting constant pain and radiating symptoms in his upper extremity. Examination of upper extremity on 03/19/15 shows decreased sensation in the C6 and C7 nerve distributions. Given that the patient has not had this test performed in the past and the patient's continuing radiating symptoms in his upper extremity and clinical findings, the request IS medically necessary.

12 Physical Therapy sessions for bilateral shoulders: Upheld

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

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

Decision rationale: The patient presents with pain and weakness in his neck, shoulder and upper extremity. The patient is s/p multiple surgeries including lumbar fusion in 2014 and left elbow surgery in 2014 from previous auto accident. The request is for 12 SESSIONS OF

PHYSICAL THERAPY FOR THE BILATERAL SHOULDERS. RFA is not provided. Regarding work statue, the patient is currently working. For non-post-operative therapy treatments MTUS guidelines page 98 and 99 allow 8-10 sessions for neuralgia, neuritis, and radiculitis, unspecified and 9-10 sessions for myalgia and myositis, unspecified. In this case, the patient appears to have not tried physical therapy since he was injured on 03/06/15. A short course of physical therapy may be reasonable to address the patient's shoulder pain and symptoms. However, the requested 12 sessions would exceed what is allowed per MTUS for this kind of condition. The utilization review letter on 04/17/15 modified 12 sessions to 10 sessions. The requested 12 sessions of physical therapy IS NOT medically necessary.

Kera-Tek analgesic gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Kera-Tek analgesic gel, Salicylate topicals.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topical; Topical analgesic Page(s): 105, 111-113.

Decision rationale: The patient presents with pain and weakness in his neck, shoulder and upper extremity. The patient is s/p multiple surgeries including lumbar fusion in 2014 and left elbow surgery in 2014. The request is for KERA-TEK ANALGESIC GEL. RFA is not provided. Per 03/25/15 progress report, the patient is taking Acataminophen, Nabumetone and Orphenadrine. Regarding work statue, the patient is currently working. Kera- Tek analgesic gel contains MENTHOL 16g in 100g and METHYL SALICYLATE 28g in 100g. Regarding topical analgesics, MTUS states they are largely experimental in use with few randomized controlled trials to determine efficacy or safety, and recommends for neuropathic pain when trials of antidepressants and anti-convulsants have failed. Methyl salicylate and menthol are recommended under MTUS Salicylate topical section, page 105 in which Ben-Gay (which contains menthol and methyl salicylate) is given as an example and is stated as significantly better than placebo in chronic pain. Topical NSAIDs are indicated for peripheral joint arthritis/tendinitis problems. "Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. " In this case, the patient has not utilized this medication in the past. There is no documentation that the patient presents with peripheral joint arthritis/tendinitis problems for which this product may be indicated. Furthermore, the request does not specify the amount of gel. The request IS NOT medically necessary.