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| Case Number: | CM14-0149404 | | |
| Date Assigned: | 09/18/2014 | Date of Injury: | 07/04/2013 |
| Decision Date: | 10/17/2014 | UR Denial Date: | 08/22/2014 |
| Priority: | Standard | Application Received: | 09/15/2014 |

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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Record indicates the insured as having complaints of left shoulder pain, neck pain, burning pain in the interscapular mid region and low back pain. There are headaches in the occipital and vertex area as well as report of worsening of depression. There is a report of 03/07/14 the insured has undergone an AME examination with an impression of status post arthroscopic surgery to the right shoulder, manipulation under anesthesia of the right shoulder and a re-operation of the right shoulder and status post left shoulder surgery. Physical examination indicated muscle strength as being 5/5 in the lower extremities but was 3-/5 in the left shoulder abduction, flexion due pain with right shoulder abduction, flexion 5-/5 due to pain. Gait was usual except for the patient keeps the left shoulder guarded due to pain. Sensation was decreased in the medial forearm, medial hand and fourth and fifth fingers in a C8 dermatomal pattern to light touch and pinprick. Straight leg raise was negative bilaterally and Spurling's sign was negative bilaterally. There is a report and overall diagnosis as listed as history of left shoulder arthroscopy with cervical strain with hypesthesia in the C8 dermatomal pattern with intermittent thoracic pain with burning sensation and intermittent lumbar spine pain. Note July 8, 2014, indicated the insured is being seen for reevaluation as an agreed medical examiner in orthopedics. The insured was reporting that her condition has worsened since stopping physical therapy. Examination indicated no subacromial crepitation and there were complaints of tenderness in the acromioclavicular area and in the subacromial area of the left shoulder. Impression was status post subacromial decompression of the left shoulder with adhesive capsulitis of the left shoulder and was recommended for additional physical therapy by the evaluating provider.

IMR ISSUES, DECISIONS AND RATIONALES

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

Emg of bilateral upper extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Wrist, & Hand (updated 8/8/14)Electrodiagnostics studies (EDS)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - upper extremity, EMG Recommended (needle, not surface) as an option in selected cases. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive (50%-71%) and highly specific (65%-85%). (AAEM, 1999) EMG findings may not be predictive of surgical outcome in cervical surgery, and patients may st

Decision rationale: The medical records provided for review support the insured has neurologic deficits of weakness in distribution of more than one peripheral nerve and/or root and as such supports EMG to provide for diagnostic evaluation and guide therapy.

Xanax 1 mg qd as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - pain, benzodiazepines Not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities). Their range of action includes sedativ

Decision rationale: The medical records provided for review do not indicate condition of spasticity unresponsive to other standard treatments or indicate a condition that supports long term treatment with Xanax. ODG guidelines do not support Xanax for long term use due to rapid habituation. This request is not medically necessary.

Follow up with ██████████ in 6 weeks: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (updated 7/29/14)Office visits

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines neck pain Page(s): 301-310.

Decision rationale: The medical records support a condition of pain for which follow-up care with specialist is supported to guide treatment and improve functionality. This request is medically necessary.

Continued physical therapy to left shoulder 2 x week for 6 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -shoulder, physical therapy Adhesive capsulitis: For adhesive capsulitis, injection of corticosteroid combined with a simple home exercise program is effective in improving shoulder pain and disability in patients. Adding supervised physical therapy provides faster improvement in shoulder range of motion. When used alone, supervised physical therapy is of limited efficacy in the management of adhesive capsulitis. (Carette,

Decision rationale: The medical records provided for review support the insured has regressed since stopping guided therapy and is not making gains on own for improving her functionality. Therefore, this request is medically necessary.

Ncv of bilateral upper extremities: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -neck and upper back, NCV Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards: (1) EDX testing should be medically indicated. (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening

Decision rationale: The medical records provided for review support the insured has neurologic deficits of weakness in distribution of more than one peripheral nerve and/or root and as such supports NCV to provide for diagnostic evaluation and guide therapy. This request is medically necessary.