

Case Number:	CM15-0016593		
Date Assigned:	02/04/2015	Date of Injury:	07/02/2013
Decision Date:	03/27/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/28/2015

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: TR, California, Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational 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 (IW) is a 50 year old female who sustained an industrial injury on 07/02/2013. She has reported continued neck pain and bilateral shoulder pain with the left shoulder worse than the right, and weakness in the left hand so that she has to have assistance shopping and cannot pick up her grandchild. Without medication, she rates her pain level at 8/10 and a 6.5 to 7.0 /10 with medication. Diagnoses include cervical strain, left shoulder sprain, left elbow sprain, left wrist sprain, and cervical disc disease. Treatments to date include medication management with a pain management specialist. In a progress note dated 10/29/2014, the treating provider reports stiffness and tightness on the left side of the cervical paravertebrals. Cervical range of motion is decreased. Tenderness is noted in the left acromioclavicular joint and subacrominal space. Left shoulder range of motion is restricted and painful. There is no evidence of carpal tunnel syndrome. The IW is on modified work duties. On 12/31/2014 Utilization Review non-certified a request for Daypro 600mg, #60, noting the there was no indication of the IW's updated response to this medication. The records do not clarify that the IW has failed first-line nonsteroidal anti-inflammatories. The MTUS Chronic Pain was cited. On 12/31/2014 Utilization Review non-certified a request for NCV/EMG Upper Extremities noting the prior examinations had not clearly indicated the presence of neurologic deficits on exam to warrant electrodiagnostic testing. The MTUS, ACOEM Guidelines were cited. On 12/31/2014 Utilization Review non-certified a request for Physical Therapy 2 times a week for 4 weeks, noting there was prior certification for an initial 2 sessions for the left shoulder and neck, and no progress notes have been received relative to the effectiveness of the therapy. The MTUS

Chronic Pain, Physical Medicine Guidelines were cited. On 12/31/2014 Utilization Review non-certified a request for Tylenol #3, quantity: 90 noting the prior request of 08/19 non-certified the Tylenol #3, and by the IW's report, not only were the Tylenol #3's felt to be not helpful, she appeared to be self-dosing and running out of them early. The MTUS Chronic Pain was cited. On 12/31/2014 Utilization Review non-certified a request for Urine Toxicology Screen, noting the Tylenol #3 has been non-certified, making the patient inappropriate for a urine toxicology screen; the MTUS Chronic Pain, Opioids was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol #3, quantity: 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain treatment in this patient since the initial date of injury (7/2/13), consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case the patient has reported that the Tylenol #3 was not helpful when taken, and it appears that with self-dosing she was running out of them early. A prior request for Tylenol #3 on 08/19 was rejected. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Given the historical lack of efficacy and potential adverse effects, and lack of functional improvement in light of the chronic nature of this case, the request for Tylenol #3 is not considered medically necessary.

Daypro 600mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 73.

Decision rationale: The MTUS chronic pain guidelines list Daypro for osteoarthritis off-label use for mild to moderate pain, but without evidence of failure at first line NSAID treatments in the provided documents and no objective measure of improvement on the medication, the request cannot be considered medically necessary.

Physical Therapy 2 times a week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: The MTUS Chronic Pain Management Guidelines (pg 58-59) indicate that manual therapy and manipulation are recommended as options in low back pain. A prior certification of physical therapy occurred per the record, but no progress notes in the provided documents indicate the level of effectiveness/functional improvement following treatment. With respect to therapeutic care, the MTUS recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement allowing for up to 18 visits over 6-8 weeks. If the case is considered a recurrence/flare-up, the guidelines similarly indicate a need to evaluate treatment success. In either case, whether considered acute or recurrent, the patient needs to be evaluated for functional improvement prior to the completion of 8 visits in order to meet the standards outlined in the guidelines. Overall, while previous records indicate a lack of objective evidence to support functional improvement with prior extensive physical therapy treatment, it is possible the patient may benefit from conservative treatment with manual therapy at this time. However, early re-evaluation for efficacy of treatment/functional improvement is critical. The guidelines indicate a time to produce effect of 4-6 treatments, which provides a reasonable timeline by which to reassess the patient and ensure that education, counseling, and evaluation for functional improvement occur. In this case, the request for a total of 8 visits to physical therapy without a definitive plan to assess for added clinical benefit prior to completion of the entire course of therapy is not considered medically necessary.

NCV/EMG Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): (s) 177-178, 261, 309. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 177-178.

Decision rationale: Per the MTUS ACOEM Guidelines, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic exam is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and nerve conduction velocities may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case there is no provided indication of neurologic dysfunction that is evidential of need for electrodiagnostics, and therefore, per the guidelines, the request for EMG/NCV is not considered medically necessary.

Urine Toxicology Screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 89.

Decision rationale: The MTUS Chronic Pain guidelines describe urine drug testing as an option to assess for the use or presence of illegal drugs. Given this patient's history and previous non-certifications by utilization review for controlled substances, and without documentation of concerns for abuse/misuse or aberrant behavior, further screening cannot be substantiated at this time and is therefore not considered medically necessary.