

Case Number:	CM15-0017086		
Date Assigned:	03/10/2015	Date of Injury:	10/03/2014
Decision Date:	06/25/2015	UR Denial Date:	01/13/2015
Priority:	Standard	Application Received:	01/27/2015

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: New York
 Certification(s)/Specialty: Pediatrics, Internal 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 47 year old female, who sustained an industrial injury on 10/3/14. She has reported neck, back and shoulder injuries. The diagnoses have included brachial neuritis or radiculitis, thoracic or lumbar neuritis or radiculitis, other affections of shoulder region, shoulder impingement and carpal tunnel. Treatment to date has included medications, diagnostics, injections, physical therapy and splinting. Currently, per the physician progress note dated 12/19/14, the injured worker has had no significant improvement since last exam and was presenting for a right shoulder injection. Physical exam of the cervical spine revealed spasm, tenderness and reduced sensation. The bilateral shoulders revealed tenderness to pressure, restricted range of motion on the right and left and positive impingement sign right and left. The wrists revealed positive Finkelstein's and Tinel's right and left wrists. The lumbar spine revealed spasm, tenderness, decreased sensation in bilateral feet and restricted range of motion. There was positive straight leg raise noted right and left. Magnetic Resonance Imaging (MRI) of the right shoulder dated 12/20/14 revealed tear of the tendon, tendinitis, and tenosynovitis. Work status was to return to regular work. On 1/13/15 Utilization Review modified a request for Physical therapy for the neck, right shoulder and low back, 3 times a week for 4 weeks modified to 6 sessions and Orphenadrine ER 100mg, #60 with 2 refills modified to Orphenadrine ER 100mg, #7 with 0 refills for weaning, noting the (MTUS) Medical Treatment Utilization Schedule chronic pain Physical Medicine pages 98-99 were cited and (MTUS) Medical Treatment Utilization Schedule chronic pain Muscle relaxants (for pain) pages 63 and 65 were cited. On 1/13/15, Utilization Review non-certified a request for EMG/NCS of the bilateral upper extremities, EMG/NCS of the bilateral lower extremities, MRI of the neck, MRI of the low back, MRI of the right shoulder, and Omeprazole DR 20mg, #30

with 2 refills, noting the (MTUS) Medical Treatment Utilization Schedule and (ACOEM) Occupational Medicine Practice Guidelines chapter 8 neck and upper back complaints and chapter 12 low back complaints were cited, the (MTUS) Medical Treatment Utilization Schedule and (ACOEM) Occupational Medicine Practice Guidelines chapter 8 neck and upper back complaints, (MTUS) Medical Treatment Utilization Schedule and (ACOEM) Occupational Medicine Practice Guidelines chapter 9 shoulder complaints was cited, the (MTUS) Medical Treatment Utilization Schedule chronic pain Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) , GI symptoms and cardiovascular risk pages 68-69 were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the neck, right shoulder and low back, 3 times a week for 4 weeks:
Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Shoulder and Neck Chapters.

Decision rationale: Physical therapy is recommended by MTUS for chronic pain if caused by musculoskeletal conditions. Direction from physical and occupational therapy providers can play a role in this, with the evidence supporting active therapy and not extensive use of passive modalities. With regards to Thoracic/lumbosacral neuritis/radiculitis it is recommended as an option, 10-12 visits over 8 weeks. Neck guidelines state that the IW should receive 12 visits over 10 weeks for treatment. With regards to the shoulder treatment is recommended for 10 visits over 8 weeks. There is little information regarding previous treatments and possible history of physical therapy, duration and response. The medical necessity of this request is unable to be affirmed. The request is not medically necessary.

EMG/NCS of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter.

Decision rationale: Per ODG guidelines EMG is recommended (needle, not surface) as an option in selected cases While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy, but these studies can result in unnecessary over treatment. As per the documentation the IW had already undergone and EMG of the upper extremities and this request is a duplication. The EMG is not medically necessary and appropriate.

EMG/NCS of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 4-8 weeks conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. There is no clear description of a radiculopathy, the IW describes shooting pain however it is not described as dermatomal in pattern nor are there clinical sensory findings consistent with a radiculopathy. This request is not medically necessary and appropriate.

MRI of the neck: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: Per ACOEM guidelines criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. The documentation shows that the IW is no radiculopathy on exam, there is no mention of possible surgery and the IW had already had the scan in December 2014. The request is not medically necessary

MRI of the low back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: According to ACOEM guidelines CT or MRI are indicated if there are red flags for cauda equina, tumor, infection, or fracture when plain films are negative and MRI is the test of choice for patients with prior back surgery. There was no documentation of concern for the above issues, the IW had no previous history of back surgery and the scan had already been completed in December 2014. The request is not medically necessary.

MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

Decision rationale: Per ACOEM guidelines the primary criteria for ordering imaging studies are emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon), failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The documentation shows that the IW is neurologically intact, there is no mention of possible surgery and the IW had an MRI of the right shoulder done in December 2014 . The request is not medically necessary.

Omeprazole DR 20mg, #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to MTUS guidelines it is necessary to determine if the patient is at risk for gastrointestinal events. Risk factors are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. There was no notation of GI symptoms or a history of risk factors. This request is not medically necessary or appropriate.

Orphenadrine ER 100mg, #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63 and 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

Decision rationale: MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. It is noted that in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The IW is noted to be on an NSAID and that the muscle relaxant is to be taken twice daily regularly. The request is not medically necessary and appropriate.