

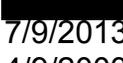


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**Notice of Independent Medical Review Determination**

Dated: 11/18/2013



Employee:   
Claim Number:   
Date of UR Decision: 7/9/2013  
Date of Injury: 4/9/2003  
IMR Application Received: 8/5/2013  
MAXIMUS Case Number: CM13-0006994

- 1) MAXIMUS Federal Services, Inc. has determined the request for **six sessions of physical therapy is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **six sessions of acupuncture is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **one EMG of bilateral upper extremities is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **one NCV of bilateral upper extremities is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Flurbiprofen cream 120ml with 1 refill is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Ultram 550mg #60 with 1 refill is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **1 SolarCare FIR heating system is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for an **MRA of the left shoulder is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/5/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **six sessions of physical therapy** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **six sessions of acupuncture** is not medically necessary and appropriate.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **one EMG of bilateral upper extremities** is not medically necessary and appropriate.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **one NCV of bilateral upper extremities** is not medically necessary and appropriate.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Flurbiprofen cream 120ml with 1 refill** is not medically necessary and appropriate.
- 6) MAXIMUS Federal Services, Inc. has determined the request for **1 prescription of Ultram 550mg #60 with 1 refill** is not medically necessary and appropriate.
- 7) MAXIMUS Federal Services, Inc. has determined the request for **1 SolarCare FIR heating system** is not medically necessary and appropriate.
- 8) MAXIMUS Federal Services, Inc. has determined the request for an **MRA of the left shoulder** is not medically necessary and appropriate.

### Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

This claimant reported an injury on 4/09/2003. On 03/26/2013, claimant was seen by the primary treating physician for initial comprehensive orthopedic evaluation. Evaluation was performed by [REDACTED], MD. The claimant stated that, during the course of employment in early 1990, claimant developed pain, numbness, and weakness in the left wrist as the result of repetitive use of the upper extremities to perform the usual job duties. The claimant subsequently was found to have positive findings on electrodiagnostic studies for carpal tunnel syndrome, and surgery was recommended and performed on 05/10/1990. The claimant stated, subsequently, in 2000, that claimant developed onset of pain to the left greater than right shoulders, left forearm and neck, and left wrist pain persistent which was attributed to claimants usual job duties as a machine operator. The claimant currently complains of left shoulder discomfort and left wrist discomfort, and denies specific pain to the neck as the pain radiates from the left shoulder. The claimant reports mild occasional dizziness, but denies headaches or tenderness. The claimant denies specific pain to the left elbow and denies specific pain to the left forearm as pain radiates from the left wrist and shoulder. Upon examination, deep tendon reflexes in the upper extremities are rated at 2+. There is diffuse decreased sensation to the left upper extremity and motor power is decreased to manual testing in the left upper extremity, rated at 5-/5. Motor power is otherwise intact. On 03/29/2013, x-rays of the cervical spine were obtained, revealing discogenic spondylosis at C2-3, and suggested missing pedicle resulting in widening of the C5, C6 and C7 intervertebral foramen. There is also apophyseal joint arthrosis at C4-5, C5-6, and C6-7 with flattening of the sagittal cervical curve and anterior shift of cervical gravity line. The claimant had an intercalary bone at C6-7 and there was bilateral carotid atherosclerosis. X-rays of the left shoulder obtained on 03/29/2013 revealed a surgical anchor at the humeral head, indicative of prior rotator cuff repair. On 06/05/2013, the claimant underwent acupuncture initial consultation by an unstated provider at [REDACTED]. On 06/05/2013 and 06/07/2013, the claimant was seen in clinic for treatment by an unstated provider. On 06/18/2013, 06/19/2013, and 06/21/2013, the claimant returned to therapy by an unstated provider. On 06/18/2013, the claimant returned to acupuncture clinic for progress note. This note is handwritten and of poor copy quality. A pre and post visual analog scale was performed on 06/05/2013 and 06/18/2013, revealing the pain level had gone up post-treatment on 06/18/2013. On 06/24/2013 and 06/25/2013, the claimant returned to clinic with further therapy by an unstated provider. A log note stated the claimant had undergone therapy to the shoulder and cervical spine on 06/03/2013, 06/07/2013, 06/10/2013, 06/14/2013, 06/17/2013, 06/21/2013, and 06/24/2013. On 07/25/2013, a therapy note indicated that the claimant had improved on forward bending from 35 degrees to 50 degrees, backward bending from 41 degrees to 45 degrees, right lateral bending not improved, stating consistent at 30 degrees, left lateral bending had improved from 29 degrees to 30 degrees, right rotation had improved from 31 degrees to 55 degrees, and left rotation had improved from 40 degrees to 45 degrees. Strength had improved from 4- to 4+ from 06/24/2013 to 07/25/2013.

### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for six sessions of physical therapy :**

##### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9) pages 201-205, which is part of the MTUS, and the Chronic Pain Medical Treatment Guidelines, physical medicine, pages 98-99, which is part of the MTUS.

##### Rationale for the Decision:

MTUS/ACOEM guidelines, Shoulder Chapter, indicate that in-home exercise should be performed, except in cases of unstable fractures, acute dislocations, instability, or hypermobility. Employees can be advised to do early active or passive range of motion exercises at home. MTUS Chronic Pain Guidelines go further, stating that for myalgia and myositis, 8 visits to 10 visits over 4 weeks should be considered reasonable, with fading of frequency of treatment from up to 3 visits per week to 1 or less, plus active self-directed home physical medicine. The submitted records indicate the employee has had a significant amount of physical therapy already without significant improvement in grip strength, pain, or strength. The employee has mild increase in some of the range of motion, but has remained static in other areas of range of motion, such as right lateral bending and left lateral bending. As such, rationale for continued physical therapy has not been demonstrated by the records provided. **The request for six sessions of physical therapy is not medically necessary and appropriate.**

#### **2) Regarding the request for six sessions of acupuncture :**

##### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Acupuncture Medical Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Acupuncture Medical Treatment Guidelines, clean copy guidelines, page 8-9, which is part of the MTUS.

Rationale for the Decision:

MTUS, Acupuncture Guidelines, Clean Copy Guidelines, pages 8 and 9, indicate that acupuncture is used as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. MTUS Clean Copy Guidelines indicate that time to produce functional improvement is 3 treatments to 6 treatments with a frequency of 1 time to 3 times per week with an optimum duration of 1 month to 2 months. The submitted records indicate that this employee has undergone acupuncture treatment, but it fails to indicate that, from 06/05/2013 through 06/18/2013, the employee had made any improvement. The pre and post visual analog scale from 06/05/2013 and 06/18/2013 actually indicates that the pain went up on 06/18/2013. The records indicate the shoulder range of motion increased 5 degrees in flexion during that time period and increased approximately 28 degrees in abduction. However, the pain has increased. The records do not indicate that this is being used as an adjunct to surgical intervention, and the records do not indicate pain medication has been reduced or not tolerated. As such, rationale for continuation of this therapy has not been demonstrated by the records provided. **The request for six sessions of acupuncture is not medically necessary and appropriate.**

**3) Regarding the request for one EMG of bilateral upper extremities :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8) page 178, which is part of the MTUS, and the Official Disability Guidelines (ODG), Neck and Upper Back Sections, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8) page 178-179, which is part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM guidelines, Neck and Upper Back Chapter, indicate that criteria for ordering electrodiagnostic studies would be if the neurological exam is less clear, then further physiological evidence of nerve dysfunction can be obtained, and nerve conduction studies may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 weeks or 4 weeks. The records indicate the employee has numbness and tingling to the left upper extremity and has an x-ray of the cervical spine, which indicates that the employee has spondylosis and degenerative changes. This would be consistent and there are no subtle focal neurological deficits noted. Therefore, the employee does have some neurological deficits to the left upper extremity, but none are noted to the right upper extremity. This request is for an EMG of the bilateral upper extremities. Rationale for providing this request to the bilateral upper extremities has not been demonstrated by the records and is not supported by guidelines. **The request for one EMG of the bilateral upper extremities is not medically necessary and appropriate.**

**4) Regarding the request for one NCV of bilateral upper extremities:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8) page 178, which is part of the MTUS, and the Official Disability Guidelines (ODG), Neck and Upper Back Sections, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8) page 178-179, which is part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM, Neck Chapter indicates that criteria for ordering electrodiagnostic studies would be if the neurological exam is less clear then further physiological evidence of nerve dysfunction can be obtained, and nerve conduction studies may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 weeks or 4 weeks. The records indicate the employee has numbness and tingling to the left upper extremity and has an x-ray of the cervical spine, which indicates that the employee has spondylosis and degenerative changes. This would be consistent. There are no subtle focal neurological deficits noted. The employee does have some neurological deficits to the left upper extremity, but none are noted to the right upper extremity. This request is for an NCV of the bilateral upper extremities. Rationale for providing this request to the bilateral upper extremities has not been demonstrated by the records and is not supported by guidelines.

**The request for one NCV of the bilateral upper extremities is not medically necessary and appropriate.**

**5) Regarding the request for 1 prescription of Flurbiprofen cream 120ml with 1 refill :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 3) pages 47-48, which is part of the MTUS, and the Chronic Pain Medical Treatment Guidelines, NSAIDs, Topical Analgesics, pages 67-73 & 111-113, which is part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM guidelines, Initial Approach to Treatment, indicate that the physician should discuss the efficacy of medication for the particular condition and side effects, and any other relevant information with the patient to ensure proper use. MTUS Chronic Pain Guidelines, in discussing topical analgesics, indicate this type of medication is largely experimental in use with few randomized control trials to determine their efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical records submitted for this review fail to indicate the overall efficacy of this medication. The records do not support the continuation of this medication due to lack of documentation of significant efficacy as the employee's pain has continued from 6/10 to 7/10 consistently, and guidelines do not support this medication as it is largely experimental. **The request for 1 prescription of Flurbiprofen cream 120ml with 1 refill is not medically necessary and appropriate.**

**6) Regarding the request for 1 prescription of Ultram 550mg #60 with 1 refill :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 3) pages 47-48, which is part of the MTUS, and the Chronic Pain Medical Treatment Guidelines, Tramadol, opioids, pages 78, 93, & 113, which is part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM Initial Approach to Treatment Guidelines indicate the physician should discuss the efficacy of medication for the particular conditions and side effects, and any other relevant information with the patient to ensure proper use. MTUS Chronic Pain Guidelines indicate that tramadol is a centrally acting synthetic opioid analgesic and is not recommended as a first line oral analgesic. Guidelines further indicate that 4 domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behavior. The submitted records indicate the employee's pain has been rated at 6/10 to 7/10 consistently. A most recent drug screen has not been provided to demonstrate lack of aberrant behavior. As the efficacy of the medication has not been demonstrated by pain scales, and lack of aberrancy has not been documented, and as there is lack of documentation of lesser medications being tried and failed, this request is not considered medically necessary. **The request for 1 prescription of Ultram 550mg #60 with 1 refill is not medically necessary and appropriate.**

**7) Regarding the request for 1 SolarCare FIR heating system :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9) pages 201-205, which is part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM guidelines, Shoulder Chapter, indicate that an employee's at home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. A rationale for this request has not been demonstrated by the records provided. Rationale for not using local ice packs or heat packs has not been demonstrated versus this heating system. **The request for 1 SolarCare FIR heating system is not medically necessary and appropriate.**

**8) Regarding the request for an MRA of the left shoulder :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9) page 208, which is part of the MTUS, and the Official Disability Guidelines, (ODG), Shoulder Section (Acute and Chronic), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9) page 207-209, which is part of the MTUS,

Rationale for the Decision:

MTUS/ACOEM guidelines indicate that imaging may be considered for employees whose limitations due to constant symptoms have persisted for 1 month or more in cases when surgery is being considered for a specific anatomic defect, such as a full thickness rotator cuff tear. The MRA would be designed to see if there is any significant labral pathology. The records do not demonstrate that the employee has a malfunction or has a pathology that would be documented by an MRA. The employee has previous x-rays which demonstrate that there is a surgical anchor at the humeral head, indicative of previous rotator cuff repair. The records do not describe the symptoms or mechanism of injury as being related to the labrum. They do not indicate the employee is a surgical candidate at this time. **The request for an MRA of the left shoulder is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.