

<b>Case Number:</b>	CM13-0039401		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	07/01/2003
<b>Decision Date:</b>	03/05/2014	<b>UR Denial Date:</b>	10/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/28/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Neurology, and has a subspecialty in Neuromuscular Medicine 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 physician 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:

██████████ is a 48 year old man who sustained a work-related injury on July 1, 2003. He subsequently developed chronic neck pain, right shoulder and elbow pain. According to ██████████ note dated on September 4, 2013, the patient was treated with Ibuprofen, Pennsaid drops, Protonix and Ultracet. The patient reported some improvement with injection to the trapezius. Physical examination demonstrated tenderness on the lateral side of the lateral epicondyle, tenderness on palpation of the cervical paraspinal area. The patient was diagnosed with cervical degeneration, right shoulder degeneration, right epicondylitis and cervical radiculitis. He requested authorization for nerve conduction study/electromyography (EMG) of the upper extremities, administration of contrast, and right trapezius injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**request for Nerve Conduction Velocity Test (NCV)/(EMG) Electromyography:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): s 212; 33.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): s 303-304, Chronic Pain Treatment Guidelines Special studies and diagnostic and treatment considerations Page(s): s 178-179, 182.

**Decision rationale:** According to MTUS guidelines Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. EMG has excellent ability to identify abnormalities related to disc protrusion. According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation. EMG is useful to identify physiological insult and anatomical defect in case of neck pain. The patient developed chronic neck pain and damage after his work related injury. There is no recent documentation of cervical radiculopathy and no recent clear other justification for the need of an EMG. Therefore, the request for EMG/NCV of bilateral upper extremities is not medically necessary.

**request for Ultracet 37.5/325 mg #90 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113.

**Decision rationale:** According to MTUS guidelines, Ultracet (Tramadol) is a central acting analgesic that may be used in chronic pain. Ultracet is a synthetic opioid affecting the central nervous system. It is not classified as a controlled substance by the DEA. It is not recommended as a first-line oral analgesic. It is not clear from the patient's chart that first-line pain medications were previously attempted. In addition, there is no documentation about the efficacy and adverse reaction profile of previous use of Ultracet. Therefore, the prescription of Ultracet 37.5/325 mg #90 with 1 refill is not medically necessary.

**request for 1 Trigger point injection to the right trapezius with DexaLido:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines trigger point injections Page(s): 122.

**Decision rationale:** According to the MTUS Guidelines, trigger point injection is recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. Not recommended for radicular pain. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in

response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. (Graff-Radford, 2004) (Nelemans-Cochrane, 2002) For fibromyalgia syndrome, trigger point injections have not been proven effective. (Goldenberg, 2004) Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. There is no clear evidence of failure of oral medication in this case. The referring physician should provide objective information and quantification of previous injection of the right trapezius as well as information about the efficacy of previous use of Ultracet. Therefore, the request for 1 trigger point injection to the right trapezius with DexaLido is not medically necessary.