

<b>Case Number:</b>	CM13-0071953		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	07/11/2000
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	12/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2013

### 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 Physical Medicine & 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 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:

The patient is a 46-year-old female who reported an injury on 07/11/2000. The mechanism of injury was not stated. The patient is diagnosed with herniated disc disease in the cervical spine and internal derangement of the right shoulder. The patient was seen on 11/20/2013. The patient reported ongoing neck pain with stiffness and radiation to bilateral hands as well as right shoulder pain. Physical examination revealed diminished sensation in all fingers bilaterally. Treatment recommendations included prescriptions for Celebrex, Tramadol, omeprazole, methocarbamol, and Ambien. A request for authorization was also submitted for an EMG and NCS of bilateral upper extremities. The patient was also administered an injection of ketorolac 60 mg with Xylocaine 1 mL.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NCV BILATERAL UPPER EXTREMITIES:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state electromyography and nerve conduction velocities may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms lasting more than 3 or 4 weeks. There was no comprehensive physical examination provided on the requesting date of 11/20/2013. Although the patient reports objective symptoms of radiating pain with numbness in bilateral hands, there is no objective evidence of radiculopathy upon physical examination. Therefore, the request for NCV bilateral upper extremities is non-certified.

**URINE DRUG SCREEN:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Page(s): 43,77,89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Urine Drug Testing

**Decision rationale:** The California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. As per the documentation submitted, the patient's injury was greater than 13 years ago to date, and there is no indication of noncompliance or misuse of medication. There is also no indication that this patient falls under a high-risk category that would require frequent monitoring. Based on the clinical information received, the request for urine drug screen is non-certified.

**TORADOL INJECTION:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Page(s): 67-72.

**Decision rationale:** The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line treatment after acetaminophen. Ketorolac is not recommended for minor or chronic painful conditions. The medical necessity for the requested service has not been established. There is also no strength or quantity listed in the current request. Therefore, the request is not medically appropriate. Therefore, the request for Toradol injection is non-certified.

**CELEBREX:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Page(s): 67-72.

**Decision rationale:** This is a nonspecific request that does not include the frequency, dosage, or quantity. Therefore, the request for Celebrex is not medically appropriate, and is non-certified.

**METHOCARBAMOL (ROBAXIN):**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Page(s): 63-66.

**Decision rationale:** This is a nonspecific request that does not include the frequency, dosage, or quantity. Therefore, the request for Methocarbamol (Robaxin) is not medically appropriate, and is non-certified.

**AMBIEN:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, and Insomnia Treatment

**Decision rationale:** This is a nonspecific request that does not include the frequency, dosage, or quantity. Therefore, the request for Ambien is not medically appropriate, and is non-certified.