MAXIMUS Federal Services

Case Number:	CM14-0115965		
Date Assigned:	08/04/2014	Date of Injury:	03/04/2011
Decision Date:	09/12/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	07/24/2014

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 and Rehabilitation, has a subspecialty in Pain Management 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 injured worker is a 38 year-old female with a date of injury of 03/04/2011. The patient's industrially related diagnoses include chronic neck pain, post-cervical laminectomy syndrome, chronic right cervical radiculopathy, and mild right carpal tunnel syndrome. Patient attended physical therapy for 5 months in 2011, had an MRI of cervical spine done on 01/28/2011 and 06/23/2011, and had a disc replacement surgery on C5-6 on 03/07/2011. An EMG was performed on 06/29/2011 of the right upper extremities and on 01/11/2012 of bilateral upper extremities. The disputed issues are EMG/NCS of bilateral upper extremities, cervical epidural steroid injection at C7-T1, Tramadol 50mg #60, and Soma 350mg #30. A utilization review determination on 07/22/2014 had non-certified the cervical epidural steroid injection C7-T1 and EMG/NCV of bilateral UE. Ultram was certified at #60 and Soma was only partially certified at #20. The stated rationale for the denial of the EMG/NCS was that "there is no documentation of clear rationale for the repeat EMG/NCV study." The request for cervical epidural steroid injection was not certified because "it is noted that the claimant underwent cervical epidural steroid injection in the past, but it was of no benefit. Without documentation of adequate response to prior epidural injection, the medical necessity of the request is not established." A partial certification for Soma was recommended at #20 tablets. The stated rational was that "there is no documentation of failed trials of "Y" drugs in this class and documentation indication that this medication is more beneficial to the claimant than a "Y" drug on the ODG formulary. Taking these factors in consideration, including ODG recommendations regarding use of this medication for less than two weeks, and due to the risks of withdrawal symptoms from abrupt discontinuation" it was only partially certified. The stated rational for the certification of Ultram was that "the claimant has signification complaints of pain and noted deficits on exam, the medical necessity of this medication is established for pain management."

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography bilateral upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 117-118, 271-273.

Decision rationale: 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 examination are sufficient evidence to warrant imaging studies if symptoms persist. 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. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected.Guidelines recommend nerve conduction studies for median (B) or ulnar (C) impingement at the wrist after failure of conservative treatment. There is recommendation against routine use of NCV or EMG in diagnostic evaluation of nerve entrapment or screening in patients without symptoms (D). The ACOEM guidelines state appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. EMG/NCS is recommended to evaluate for cervical radiculopathy. The injured worker had an EMG/MCS of the right upper extremities on 06/29/2011 and another one of bilateral upper extremities was performed on 01/11/2012. A third EMG/NCV was performed in 2013. On the progress note dated 06/30/2014 the treating physician requested another EMG/NCV of bilateral upper extremities. However, there is no documentation of new symptoms or significant change or progression of the injured worker's symptoms that would support the need to repeat the studies. Therefore due to the lack of supporting documentation, EMG/NCS of bilateral upper extremities is not medically necessary.

Nerve conduction velocity bilateral upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 117-118, 271-273.

Decision rationale: EMG/NCS is recommended to evaluate for cervical radiculopathy. The injured worker had an EMG/MCS of the right upper extremities on 06/29/2011 and another one of bilateral upper extremities was performed on 01/11/2012. A third EMG/NCV was performed in 2013. On the progress note dated 06/30/2014 the treating physician requested another EMG/NCV of bilateral upper extremities. However, there is no documentation of new symptoms or significant change or progression of the injured worker's symptoms that would support the need to repeat the studies. Therefore due to the lack of supporting documentation, EMG/NCS of bilateral upper extremities is not medically necessary.

Cervical epidural steroids injections: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 47.

Decision rationale: The California Medical Treatment and Utilization Schedule recommended ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. The purpose of an ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Injections should be performed using fluoroscopy (live x-ray) for guidance.If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a

general recommendation of no more than 4 blocks per region per year. Current research does not support"series-of-three" injections in either the diagnostic or therapeutic phase. The injured worker had a C7-T1 cervical epidural on 03/30/2010. The injured worked reported "that the epidural wasn't helpful at all" to one provider but earlier to another provider she said the epidural helped the pain down her right arm and she could work her regular job duties and attend physical therapy. Due to the contradictory reports on the results of the epidural injection that was done over 4 years, medical necessity is determined based on more recent imaging studies (i.e. MRI 06/23/11) and physical examination done at the most recent visit on 06/30/2014. Based on the guidelines stated above, the injured worker meets to criteria for the use of cervical epidural steroid injection. Therefore, this is considered medically necessary.

Soma 350mg quantity #30: 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: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-65.

Decision rationale: Guidelines recommend using non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, 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 injured worker's DOI was 03/04/2011 and she continues to be prescribed Soma 350 mg. Based on the guidelines stated above, Soma is not recommended for longer than a 2 to 3 week period. Due to the risks associated with prolonged use and the decreased benefit, muscle relaxants are recommended for "short-term treatment of acute exacerbations in patients with chronic LBP" as stated above. However, "withdrawal symptoms may occur with abrupt discontinuation." The injured worker should wean as instructed by the primary treating physician. Therefore the utilization review determination is upheld for a partial certification of Soma 350mg #20 tablets to allow for weaning. Therefore, this request is considered not medically necessary.

Ultram 50mg quantity #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 94, 78-79.

Decision rationale: Guidelines state that Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain." Since tramadol is an opioid, it is subject to the ongoing monitoring requirements as stated in the guidelines that on-

going management. Actions should include; prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy, the lowest possible dose should be prescribed to improve pain and function, ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The injured worker reports to have moderate to severe pain at the time Ultram was prescribed and reports that this medication helps her pain. However, as stated in the guidelines, the recommended actions need to be documented for ongoing management with this medication. Therefore this request is medically necessary.