

Case Number:	CM15-0025631		
Date Assigned:	02/18/2015	Date of Injury:	12/08/2009
Decision Date:	04/07/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/10/2015

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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 47 year old male injured worker suffered and industrial injury on 12/8/2009. The diagnoses were neural encroachment in the cervical spine with radiculopathy, lumbar disc protrusion, lumbar spondylosis, thoracic disc protrusion and progressive neurological deficit of the right upper extremity. The treatments were right shoulder surgery 2013, physical therapy, lumbar brace, TENS unit and medication. The treating provider reported pain in the right shoulder, low back pain, thoracic pain, cervical pain with tenderness of the right shoulder. The Utilization Review Determination on 1/27/2015 non-certified: 1. Physical Therapy Cervical Spine Additional Physical Therapy Lumbar Spine 3x4, citing MTUS. 2. EMG/NCV Bilateral Upper Extremities, citing MTUD ACOEM. 3. Tramadol 50mg, citing MTUS. 4. Soma 350mg, citing MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Cervical Spine Additional Physical Therapy Lumbar Spine 3x4: Upheld

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

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

Decision rationale: The patient was injured on 12/08/09 and presents with pain in the right shoulder, low back pain, thoracic pain, cervical pain with tenderness of the right shoulder. The request is for PHYSICAL THERAPY CERVICAL SPINE ADDITIONAL PHYSICAL THERAPY LUMBAR SPINE 3 X 4. The RFA is dated 01/19/15 and the patient is permanent and stationary. As of 05/30/14, the patient has had 20 sessions of physical therapy. MTUS page 98 and 99 has the following: "Physical Medicine: Recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS Guidelines page 98 and 99 states that for myalgia and myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits are recommended. Review of the reports provided does not indicate if the patient had a recent surgery. The patient has already completed at least 20 sessions of therapy. An additional 12 sessions of therapy to the 20 session the patient has already had exceeds what is allowed by MTUS guidelines. Therefore, the requested physical therapy IS NOT medically necessary.

EMG/NCV Bilateral Upper Extremities: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 206. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (acute and chronic) Chapter, EMG studies.

Decision rationale: The patient was injured on 12/08/09 and presents with pain in the right shoulder, low back pain, thoracic pain, cervical pain with tenderness of the right shoulder. The request is for EMG/NCV BILATERAL UPPER EXTREMITIES. The RFA is dated 01/19/15 and the patient is permanent and stationary. Review of the reports provided does not indicate if the patient had a prior EMG/NCV of the bilateral upper extremities. ACOEM Guidelines page 206 states: "appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions such as cervical radiculopathy. This may include nerve conduction studies (NCS) or in more difficult cases, electromyography (EMG) may be helpful. EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later and the course of treatment if symptoms persist. ODG Guidelines on the neck and upper back (acute and chronic) chapter under the section called EMG states that EMG is recommended as an option in select cases. ODG further states regarding EDS in carpal tunnel syndrome recommended in patients with clinical signs of CTS and may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), with the additional electromyography (EMG) is not generally necessary." There is no prior EMG/NCV testing done on the patient's upper extremities. The patient has been complaining about his neck and right shoulder pain as early as the 09/13/13. He has tenderness of the right shoulder. The patient is diagnosed with neural encroachment in the cervical spine with radiculopathy, lumbar disc protrusion, lumbar spondylosis, thoracic disc protrusion and

progressive neurological deficit of the right upper extremity. Past treatments include right shoulder surgery 2013, physical therapy, lumbar brace, TENS unit and medications. The 12/18/14 report states that "upper extremity neurologic component continues to crescendo with resultant decline in activity/function. Neurologic findings are consistent with C6 and C7, motor and sensory." In this case, the patient has neural encroachment C6-7 with radiculopathy and progressive neurologic deficit in his right upper extremity, as indicated by ACOEM guidelines. Therefore, the requested EMG/NCV of the upper extremities IS medically necessary.

Tramadol 50mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient was injured on 12/08/09 and presents with pain in the right shoulder, low back pain, thoracic pain, cervical pain with tenderness of the right shoulder. The request is for TRAMADOL 50 MG. The RFA is dated 01/19/15 and the patient is permanent and stationary. The patient has been taking Tramadol since 09/11/14. MTUS Guidelines pages 88 and 89 states, "pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior) as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. On 09/11/14, the patient denies side effects and rates his right shoulder pain, thoracic pain, and low back pain as a 5/10. He rates his cervical spine pain as a 7/10. On 12/18/14, he rates his low back pain and cervical spine pain as a 6/10. He rates his thoracic spine pain as a 5/10. In this case, none of the 4As are addressed as required by MTUS Guidelines. The treater does not provide any before-and-after pain scales with the use of Tramadol. There are no examples of ADLs which demonstrate medication efficacy, nor are there any discussions provided on adverse behavior/side effects. There is no pain management issues discussed such as CURES reports, pain contract, et cetera. No outcome measures are provided either as required by MTUS Guidelines. There are no urine drug screens provided to see if the patient is compliant with his medications. The treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Tramadol IS NOT medically necessary.

Soma 350mg: Upheld

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

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

Decision rationale: The patient was injured on 12/08/09 and presents with pain in the right shoulder, low back pain, thoracic pain, cervical pain with tenderness of the right shoulder. The request is for SOMA 350 MG. The RFA is dated 01/19/15 and the patient is permanent and stationary. MTUS Guidelines, pages 63-66, "Carisoprodol (Soma): Neither of these formulations is recommended for longer than a 2- to 3-week period." This has been noted for sedated and relaxant effects. The patient has tenderness of the right shoulder and is diagnosed with neural encroachment in the cervical spine with radiculopathy, lumbar disc protrusion, lumbar spondylosis, thoracic disc protrusion and progressive neurological deficit of the right upper extremity. Past treatments include right shoulder surgery 2013, physical therapy, lumbar brace, TENS unit and medications. There is no mention of the patient having any spasm in the progress report provided. MTUS recommends the requested Soma for no more than 2 to 3 weeks. In this case, the treater has requested for Soma (quantity of tablets not provided). The treater is unclear if Soma is for a short-term use, as indicated by MTUS Guidelines. Therefore, the requested Soma IS NOT medically necessary.