

<b>Case Number:</b>	CM15-0218135		
<b>Date Assigned:</b>	11/10/2015	<b>Date of Injury:</b>	06/24/2010
<b>Decision Date:</b>	12/21/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2015

### 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: Montana, Oregon, Idaho  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 26-year-old female who sustained an industrial injury on 6-24-2010 and has been treated for cervical discogenic condition, right shoulder impingement syndrome, bicipital tendonitis, rotator cuff strain, and pain in unspecified upper arm. MRI of 9-5-2013 showed loss of cervical lordosis and disc bulge at C5-6 and C6-7. On 3-20-2011, she underwent right shoulder rotator cuff repair, bursectomy and coracocacromial release, acromioplasty, and modified Mumford procedure, but is noted to still have discomfort. On 10-5-2015, the injured worker reported right shoulder pain rated at 7 out of 10, which is noted to increase to 8 without medication. She also has right upper extremity pain. She reported having problems sleeping, headaches, and depression. Objective findings include acromioclavicular joint tenderness with palpation, biceps groove, and coracoid process. Cervical range of motion was stated as "normal." The right shoulder movements were restricted. Documented treatment includes 24 physical therapy sessions with improvement, TENS unit, Tramadol, and Tylenol. The injured worker has tried Norco but with gastrointestinal symptoms, and Oxycodone caused itching. The physician states in the 10-5-2015 note that the injured worker is "stable on current medication regimen and has not changed essential regimen in greater that six months." A pain agreement is documented as being reviewed by the injured worker. No urine drug screen or discussion of medication behaviors is present. In this note, the physician also states that an electromyography had been previously requested and they were still waiting for approval. The note of 8-3-2015 documents the intent to request electromyography and nerve conduction studies of the right upper extremity, but rationale is not evidenced in the documents provided. The treating physician's plan of care includes Tramadol HCL 50 mg tablets #130, and electromyogram-nerve conductions study for the right upper extremities, which was non-certified on 10-12-2015.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol HCL (hydrochloride) 50mg tablet, 1 twice daily as needed, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. 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. 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 non-adherent) 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. Opioids may be continued if the patient has returned to work and the patient has improved functioning and pain. According to the ODG pain section a written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. The lowest possible dose should be prescribed to improve pain and function. Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control is recommended. Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. The ODG (Pain / Opioids for chronic pain) states "According to a major NIH systematic review, there is insufficient evidence to support the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms." In this case the worker 26 years old and was injured in 2010. She has undergone a right shoulder rotator cuff repair in 2011 and is being treated for cervical degenerative disc disease. Based on the documentation there is insufficient evidence to recommend the chronic use of opioids. There is no documentation of increased level of function,

a meaningful percentage of pain relief, duration of pain relief, compliance with urine drug screens, or that the injured worker has returned to work. The current guidelines provide very limited support to recommend treatment of non-malignant pain beyond 16 weeks. Therefore, the criteria set forth in the guidelines have not been met and the request is not medically necessary.

**Electromyogram (EMG)/Nerve conduction study (NCS) of the right upper extremities:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC) Pain Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck.

**Decision rationale:** CA/MTUS ACOEM Neck and Upper Back Chapter, page 178, states, 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. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). The ODG neck section states the nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) (Lin, 2013) While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. Studies have not shown portable nerve conduction devices to be effective. In this case, the submitted documentation does not provide objective justification why an EMG is being ordered. The note from 10/5/15 does not demonstrate any objective findings consistent with neurologic dysfunction. There is no documentation of sensory or motor deficits or nerve root tension signs. There is no evidence provided in the documentation of radiculopathy, brachial plexopathy or diabetic neuropathy, which would warrant an EMG of the upper extremity. In addition, there are no documented signs of peripheral nerve compression in the medical records. Therefore, the request is not medically necessary.