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| <b>Case Number:</b>   | CM15-0040506 |                              |            |
| <b>Date Assigned:</b> | 03/10/2015   | <b>Date of Injury:</b>       | 02/17/2012 |
| <b>Decision Date:</b> | 04/16/2015   | <b>UR Denial Date:</b>       | 02/23/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/03/2015 |

### 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, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 44 year old male who sustained a cumulative work related injury to his right upper extremity as a landscaper on February 17 2012. The injured worker was diagnosed with right wrist sprain/strain with tendinitis, right shoulder sprain/strain with tendinitis, cubital tunnel syndrome of the right elbow and mild dyspepsia. According to the most current report available from the primary treating physician on November 18, 2014, the patient was seen for medication refills and a flare up of right shoulder and right elbow pain. Examination demonstrated tenderness in the right shoulder girdle with decreased range of motion and pain with movement. Impingement test was slightly positive on the right. Due to the increasing shoulder pain the primary treating physician requested refills of Norco and Prilosec and bilateral upper extremity Electromyography (EMG)/Nerve Conduction Velocity (NCV) studies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #90:** 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 Opiates Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Opiates.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Norco 10/325 mg # 90 is not medically necessary. Ongoing, chronic opiate use requires an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. A detailed pain assessment should accompany ongoing opiate use. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improve quality of life. The lowest possible dose should be prescribed to improve pain and function. Discontinuation of long-term opiates is recommended in patients with no overall improvement in function, continuing pain with evidence of intolerable adverse effects or a decrease in functioning. In this case, the injured workers working diagnoses are right wrist sprain/strain; right shoulder sprain/strain; dyspepsia mild; cubital tunnel syndrome right elbow. The documentation encompasses progress notes from August 26 2014 through November 18, 2014. The treating physician prescribed Norco as far back as August 26, 2014. The worker received a refill September 23, 2014. Documentation does not contain evidence of objective functional improvement. There are no risk assessments in the medical record. Consequently, absent clinical documentation with objective functional improvement in the absence of risk assessments and detailed assessments (with ongoing opiate use), Norco 10/325 mg #90 is not medically necessary.

**Protonix 20mg #30:** 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 Omeprazole Page(s): 67-68.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Protonix 20 mg #30 is not medically necessary. Omeprazole is a proton pump inhibitor. Proton pump inhibitors are indicated in certain patients taking non-steroidal anti-inflammatory drugs that are at risk for gastrointestinal events. These risks include, but are not limited to, age greater than 65; history of peptic ulcer, G.I. bleeding; concurrent use of aspirin of corticosteroids; or high-dose multiple non-steroidal anti-inflammatory drugs. In this case, the injured workers working diagnoses are right wrist sprain/strain; right shoulder sprain/strain; dyspepsia mild; cubital tunnel syndrome right elbow. The documentation encompasses progress notes from August 26 2014 through November 18, 2014. The documentation indicates the injured worker was taking Prilosec 40 mg in the November 18, 2014 progress note. The recommended dose for Protonix is 20 mg one daily. The documentation indicates the injured worker suffers with mild dyspepsia in the diagnosis section progress note. There are no specific past medical or comorbid conditions noted in the medical record indicating risk factors for gastrointestinal events. Dyspepsia without peptic ulcer disease, G.I. bleeding, concurrent use of aspirin may be treated by changing non-steroidal anti-inflammatory drugs, discontinuing non-steroidal anti-inflammatory drugs or adding an H2 receptor blocker or, ultimately, a proton pump

inhibitor. The documentation does not reflect a change in non-steroidal anti-inflammatory drugs or use of any H2 receptor blocker. Consequently, absent clinical documentation with comorbid conditions or a past medical history with risk factors for gastrointestinal events (supra), Protonix 20 mg #30 is not medically necessary.

**Outpatient electromyograph (EMG) nerve conduction velocity (NCV) to the bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS 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) Neck section, EMG/NCV.

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV of the bilateral upper extremities is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging 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. 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-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. In this case, the injured workers working diagnoses are right wrist sprain/strain; right shoulder sprain/strain; dyspepsia mild; cubital tunnel syndrome right elbow. Subjectively, according to a November 18, 2014 progress note, injured worker is describing (according to the treating physician) an acute flare-up of right shoulder and right elbow pain. The pain worsens with any type of physical activity. Objectively, there is tenderness in the right shoulder girdle and into the right supra-medial scapula. Right shoulder range of motion is decreased in flexion and abduction. There is no neurologic evaluation of the upper extremities or lower extremities. Consequently, absent clinical documentation with radicular or neuropathic symptoms and objective neurologic findings, EMG/NCV of the bilateral upper extremities is not medically necessary.