

<b>Case Number:</b>	CM15-0063283		
<b>Date Assigned:</b>	04/20/2015	<b>Date of Injury:</b>	01/30/2012
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	03/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 49-year-old male, who sustained an industrial injury on 1/30/12. He reported neck and left shoulder pain. The injured worker was diagnosed as having cervical sprain/strain, left shoulder rotator cuff tear status post arthroscopic repair with residuals, MRI evidence of labral tear in the left shoulder with signs of impingement, right shoulder sprain/strain secondary to compensatory factors, and sleep, psych and stomach issues. Treatment to date has included physical therapy and medications. A physician's report dated 3/9/15 noted neck pain was rated 5-7/10, right shoulder pain was rated as 3/10, and left shoulder was rated a 6-7/10. The physician noted Norco reduced pain from 7/10 to 4/10. Soma reduced pain from 7/10 to 4/10. Omeprazole was noted to help with gastrointestinal upset secondary to NSAID use in the past. Currently, the injured worker complains of cervical spine and bilateral shoulder pain. The treating physician requested authorization for Norco 10/325mg #90, Prilosec 20mg #60, Soma 350mg #60, a MRI of the cervical spine, and electromyogram/nerve conduction velocity for the right and left upper extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg QTY: 90:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96 (78, 89, 95).

**Decision rationale:** Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing 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. Documentation should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long term users of opioids should be regularly reassessed. In the maintenance phase the dose should not be lowered if it is working. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected when this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli. It is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. A review of the injured workers more recent medical records reveal documentation of improvement in pain with the use of opioids and appropriate documentation for ongoing use of opioids, therefore based on the guidelines and the injured workers response to opioids the request for Norco 10/325mg QTY: 90 is medically necessary.

**Prilosec 20mg QTY: 60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) / Proton Pump Inhibitors (PPIs).

**Decision rationale:** Per the MTUS, Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors according to specific criteria listed in the MTUS and a selection should be made based on these criteria; 1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Per the ODG, PPI's are "Recommended for patients at risk for gastrointestinal events. Prilosec (omeprazole), Prevacid (lansoprazole) and Nexium (esomeprazole magnesium) are PPIs. Healing doses of PPIs are more effective than all other therapies, although there is an increase in overall adverse effects compared to placebo. Nexium and Prilosec are very similar molecules. (Donnellan, 2010) In this RCT omeprazole provided a statistically significantly greater acid control than lansoprazole. (Miner, 2010) In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Studies suggest, however, that nearly half of all PPI prescriptions are used for unapproved indications or no indications at all. Many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec), pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). (Shi, 2008) A trial of omeprazole or lansoprazole had

been recommended before prescription Nexium therapy (before it went OTC). The other PPIs, Protonix, Dexilant, and Aciphex, should be second-line. According to the latest AHRQ Comparative Effectiveness Research, all of the commercially available PPIs appeared to be similarly effective. (AHRQ, 2011)" A review of the injured workers medical records reveal documentation of gastrointestinal irritation with the use of NSAID's, therefore based on the guidelines the request for Prilosec 20mg QTY: 60 is medically necessary.

**Soma 350mg QTY: 60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 64-65.

**Decision rationale:** Per the MTUS, recommend 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. Sedation is the most commonly reported adverse effect of muscle relaxant medications. Carisoprodol is not recommended for longer than a 2 to 3 week period. Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. Carisoprodol is classified as a schedule IV drug in several states but not on a federal level. It is suggested that its main effect is due to generalized sedation as well as treatment of anxiety. A review of the injured workers medical records reveal documentation of improvement in pain with the use of carisoprodol, therefore based on the injured workers response to carisoprodol the request for Soma 350mg QTY: 60 is medically necessary.

**MRI of the Cervical Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

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

**Decision rationale:** Per the MTUS / ACOEM, "for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: Emergence of a red flag, Physiologic evidence of tissue insult or neurologic dysfunction, Failure to progress in a strengthening program intended to avoid surgery and Clarification of the anatomy prior to an invasive procedure. A review of the injured workers medical records that are available to me do not reveal any red flags, surgical considerations or any of the above referenced criteria for imaging as recommended by the guidelines and therefore the request for MRI of The Cervical Spine is not medically necessary.

## **EMG/NCV of the Right Upper Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic)/Electrodiagnostic studies, Nerve conduction studies.

**Decision rationale:** Per ACOEM in the MTUS, most patients presenting with true neck and upper back problems do not need special studies until a 3-4 week period of conservative care fails to improve symptoms, most patients improve quickly once red-flag conditions are ruled out. Criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. 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 persists. When the neurological examination is less clear, however further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV may help identify subtle focal neurologic dysfunction in patients with neck and or arm symptoms lasting more than 3-4 weeks. Per the ODG, NCS 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 based on radiculopathy. 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. A review of the injured workers medical records reveal that cervical radiculopathy is already clinically obvious, therefore based on the guidelines the request for EMG/NCV of the Right Upper Extremity is not medically necessary.

## **EMG/NCV of the Left Upper Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic)/Electrodiagnostic studies, Nerve conduction studies.

**Decision rationale:** Per ACOEM in the MTUS, most patients presenting with true neck and upper back problems do not need special studies until a 3-4 week period of conservative care fails to improve symptoms, most patients improve quickly once red-flag conditions are ruled out. Criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue

insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. 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 persists. When the neurological examination is less clear, however further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV may help identify subtle focal neurologic dysfunction in patients with neck and or arm symptoms lasting more than 3-4 weeks. Per the ODG, NCS 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 based on radiculopathy. 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. A review of the injured workers medical records reveal that cervical radiculopathy is already clinically obvious, therefore based on the guidelines the request for EMG/NCV of the Left Upper Extremity is not medically necessary.