

Case Number:	CM15-0088354		
Date Assigned:	05/12/2015	Date of Injury:	03/05/2013
Decision Date:	09/23/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	05/07/2015

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 injured worker is a 59 year old male, who sustained an industrial injury on March 5, 2013. He reported an injury to his neck with pain radiating to the bilateral arms. Treatment to date has included physical therapy, epidural steroid injections, medications and right shoulder rotator cuff repair in April, 2014. Currently, the injured worker complains of bilateral cervical spine pain which radiates to the trapezius and down to both arms and the median three fingers. He reports that the pain occurs daily and is increased with motion. Moving his index fingers will increase the numbness and pain moving down his arm. He reports diffuse cervical spine pain and bilateral trapezial pain present with all range of motion. His right shoulder has post-operative limitation in motion and increased pain with elevation. The diagnoses associated with the request include cervical sprain/strain, status post rotator cuff repair of the right shoulder, rotator cuff tear of the left shoulder confirmed by MRI and carpal tunnel syndrome confirmed by electrodiagnostic studies. The treatment plan includes home exercise of the cervical spine, medications and repeat electrodiagnostic studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of left upper extremity: Overturned

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 12 Low Back Complaints Page(s): 303.

Decision rationale: The patient presents with pain in the bilateral shoulders, bilateral cervical spine pain that radiates to the trapezius and down to both arms and the median three fingers. The request is for EMG OF THE LEFT UPPER EXTREMITY. Patient is status post right rotator cuff repair, 04/2014. Physical examination to the cervical spine on 03/12/15 revealed tenderness to palpation in all areas of the spine and trapezius muscles. Range of motion was limited in all planes with pain. Examination to the bilateral shoulders revealed diffuse tenderness over the right greater than the left shoulder bursa and anterior capsule. There was mild supraclavicular tenderness with some radiating pain down the arm. MRI findings of the cervical spine on 04/11/13 showed a 3 mm bulge at C6-7 which together with ligamentum flavum buckling results in moderate spinal stenosis, 3 mm posterior left paracentral spinal disc protrusion at C5-6 which indents the anterior thecal sac but does not result in significant spinal stenosis, 3 mm disc bulge at C3-4 which indents the anterior thecal sac but does not result in significant spinal stenosis, mild to moderate right and mild left neural foraminal narrowing at C3-4 and C4-5 mild left foraminal narrowing at C5-6 and mild to moderate bilateral neural foraminal narrowing at C6-7, mild bilateral uncovertebral spondylosis at C3-4, C4-5, C5-6 and C6-7, mild bilateral facet atrophy at C4-5, C5-6 and C6-7, and disc dislocation at C2-3 through C6-7. Per 01/21/15 progress report, patient's diagnosis includes cervical radiculopathy, cervical sprain/strain, lumbar radiculopathy, lumbar sprain/strain, status post surgery, right shoulder, and left shoulder impingement syndrome. Patient's medications, per 03/12/15 progress report include Tramadol, Hydrocodone, Promolactin, Omeprazole, Pentaprazole, Naproxen, Zoldem and Cyclobenzaprine. Patient's work status is modified duties. For EMG, ACOEM Guidelines page 303 states Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: 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. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. The treater has not discussed this request. Review of the medical records provided does not indicate a prior EMG of the left upper extremity. In progress report dated 03/12/15, it is stated that patient's pain is daily and is increased with any movement, even moving his index fingers will increase the numbness and pain going down to his arm. Given patient's diagnosis and continued symptoms with numbness, tingling to the bilateral upper extremities, the request appears reasonable and in accordance with guidelines. Therefore, the request for EMG of left upper extremity IS medically necessary.

EMG of right upper extremity: Overturned

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 12 Low Back Complaints Page(s): 303.

Decision rationale: The patient presents with pain in the bilateral shoulders, bilateral cervical spine pain that radiates to the trapezius and down to both arms and the median three fingers. The request is for EMG OF THE RIGHT UPPER EXTREMITY. Patient is status post right rotator cuff repair, 04/2014. Physical examination to the cervical spine on 03/12/15 revealed tenderness to palpation in all areas of the spine and trapezius muscles. Range of motion was limited in all planes with pain. Examination to the bilateral shoulders revealed diffuse tenderness over the right greater than the left shoulder bursa and anterior capsule. There was mild supraclavicular tenderness with some radiating pain down the arm. MRI findings of the cervical spine on 04/11/13 showed a 3 mm bulge at C6-7 which together with ligamentum flavum buckling results in moderate spinal stenosis, 3 mm posterior left paracentral spinal disc protrusion at C5-6 which indents the anterior thecal sac but does not result in significant spinal stenosis, 3 mm disc bulge at C3-4 which indents the anterior thecal sac but does not result in significant spinal stenosis, mild to moderate right and mild left neural foraminal narrowing at C3-4 and C4-5 mild left foraminal narrowing at C5-6 and mild to moderate bilateral neural foraminal narrowing at C6-7, mild bilateral uncovertebral spondylosis at C3-4, C4-5, C5-6 and C6-7, mild bilateral facet atrophy at C4-5, C5-6 and C6-7, and disc dislocation at C2-3 through C6-7. Per 01/21/15 progress report, patient's diagnosis includes cervical radiculopathy, cervical sprain/strain, lumbar radiculopathy, lumbar sprain/strain, status post surgery, right shoulder, and left shoulder impingement syndrome. Patient's medications, per 03/12/15 progress report include Tramadol, Hydrocodone, Promolactin, Omeprazole, Pentaprazole, Naproxen, Zoldem and Cyclobenzaprine. Patient's work status is modified duties. For EMG, ACOEM Guidelines page 303 states Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: 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. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. The treater has not discussed this request. Review of the medical records provided does not indicate a prior EMG of the right upper extremity. In progress report dated 03/12/15, it is stated that patient's pain is daily and is increased with any movement, even moving his index fingers will increase the numbness and pain going down to his arm. Given patient's diagnosis and continued symptoms with numbness, tingling to the bilateral upper extremities, the request appears reasonable and in accordance with guidelines. Therefore, the request for EMG of right upper extremity IS medically necessary.

NCV of left upper extremity: Overturned

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 12 Low Back Complaints Page(s): 303.

Decision rationale: The patient presents with pain in the bilateral shoulders, bilateral cervical spine pain that radiates to the trapezius and down to both arms and the median three fingers. The request is for NCV OF THE LEFT UPPER EXTREMITY. Patient is status post right rotator cuff repair, 04/2014. Physical examination to the cervical spine on 03/12/15 revealed tenderness to palpation in all areas of the spine and trapezius muscles. Range of motion was limited in all planes with pain. Examination to the bilateral shoulders revealed diffuse tenderness over the right greater than the left shoulder bursa and anterior capsule. There was mild supraclavicular tenderness with some radiating pain down the arm. MRI findings of the cervical spine on 04/11/13 showed a 3 mm bulge at C6-7 which together with ligamentum flavum buckling results in moderate spinal stenosis, 3 mm posterior left paracentral spinal disc protrusion at C5-6 which indents the anterior thecal sac but does not result in significant spinal stenosis, 3 mm disc bulge at C3-4 which indents the anterior thecal sac but does not result in significant spinal stenosis, mild to moderate right and mild left neural foraminal narrowing at C3-4 and C4-5 mild left foraminal narrowing at C5-6 and mild to moderate bilateral neural foraminal narrowing at C6-7, mild bilateral uncovertebral spondylosis at C3-4, C4-5, C5-6 and C6-7, mild bilateral facet atrophy at C4-5, C5-6 and C6-7, and disc dislocation at C2-3 through C6-7. Per 01/21/15 progress report, patient's diagnosis includes cervical radiculopathy, cervical sprain/strain, lumbar radiculopathy, lumbar sprain/strain, status post surgery, right shoulder, and left shoulder impingement syndrome. Patient's medications, per 03/12/15 progress report include Tramadol, Hydrocodone, Promolactin, Omeprazole, Pantoprazole, Naproxen, Zoldem and Cyclobenzaprine. Patient's work status is modified duties. For EMG, ACOEM Guidelines page 303 states Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: 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. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. The treater has not discussed this request. Review of the medical records provided does not indicate a prior NCV of the right upper extremity. In progress report dated 03/12/15, it is stated that patient's pain is daily and is increased with any movement, even moving his index fingers will increase the numbness and pain going down to his arm. Given patient's diagnosis and continued symptoms with numbness, tingling to the bilateral upper extremities, the request appears reasonable and in accordance with guidelines. Therefore, the request for NCV of left upper extremity IS medically necessary.

NCV of right upper extremity: Overturned

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 12 Low Back Complaints Page(s): 303.

Decision rationale: The patient presents with pain in the bilateral shoulders, bilateral cervical spine pain that radiates to the trapezius and down to both arms and the median three fingers. The request is for NCV OF THE RIGHT UPPER EXTREMITY. Patient is status post right rotator cuff repair, 04/2014. Physical examination to the cervical spine on 03/12/15 revealed tenderness to palpation in all areas of the spine and trapezius muscles. Range of motion was limited in all planes with pain. Examination to the bilateral shoulders revealed diffuse tenderness over the right greater than the left shoulder bursa and anterior capsule. There was mild supraclavicular tenderness with some radiating pain down the arm. MRI findings of the cervical spine on 04/11/13 showed a 3 mm bulge at C6-7 which together with ligamentum flavum buckling results in moderate spinal stenosis, 3 mm posterior left paracentral spinal disc protrusion at C5-6 which indents the anterior thecal sac but does not result in significant spinal stenosis, 3 mm disc bulge at C3-4 which indents the anterior thecal sac but does not result in significant spinal stenosis, mild to moderate right and mild left neural foraminal narrowing at C3-4 and C4-5 mild left foraminal narrowing at C5-6 and mild to moderate bilateral neural foraminal narrowing at C6-7, mild bilateral unvertebral spondylosis at C3-4, C4-5, C5-6 and C6-7, mild bilateral facet atrophy at C4-5, C5-6 and C6-7, and disc dislocation at C2-3 through C6-7. Per 01/21/15 progress report, patient's diagnosis includes cervical radiculopathy, cervical sprain/strain, lumbar radiculopathy, lumbar sprain/strain, status post surgery, right shoulder, and left shoulder impingement syndrome. Patient's medications, per 03/12/15 progress report include Tramadol, Hydrocodone, Promolactin, Omeprazole, Pentaprazole, Naproxen, Zoldem and Cyclobenzaprine. Patient's work status is modified duties. For EMG, ACOEM Guidelines page 303 states Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: 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. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. The treater has not discussed this request. Review of the medical records provided does not indicate a prior NCV of the right upper extremity. In progress report dated 03/12/15, it is stated that patient's pain is daily and is increased with any movement, even moving his index fingers will increase the numbness and pain going down to his arm. Given patient's diagnosis and continued symptoms with numbness, tingling to the bilateral upper extremities, the request appears reasonable and in accordance with guidelines. Therefore, the request for NCV of right upper extremity IS medically necessary.

Naproxen 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs (NSAIDs) Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory Page(s): 22.

Decision rationale: The patient presents with pain in the bilateral shoulders, bilateral cervical spine pain that radiates to the trapezius and down to both arms and the median three fingers. The request is for NAPROXEN 550 MG #60. Patient is status post right rotator cuff repair, 04/2014. Physical examination to the cervical spine on 03/12/15 revealed tenderness to palpation in all areas of the spine and trapezius muscles. Range of motion was limited in all planes with pain. Examination to the bilateral shoulders revealed diffuse tenderness over the right greater than the left shoulder bursa and anterior capsule. There was mild supraclavicular tenderness with some radiating pain down the arm. MRI findings of the cervical spine on 04/11/13 showed a 3 mm bulge at C6-7 which together with ligamentum flavum buckling results in moderate spinal stenosis, 3 mm posterior left paracentral spinal disc protrusion at C5-6 which indents the anterior thecal sac but does not result in significant spinal stenosis, 3 mm disc bulge at C3-4 which indents the anterior thecal sac but does not result in significant spinal stenosis, mild to moderate right and mild left neural foraminal narrowing at C3-4 and C4-5 mild left foraminal narrowing at C5-6 and mild to moderate bilateral neural foraminal narrowing at C6-7, mild bilateral uncovertebral spondylosis at C3-4, C4-5, C5-6 and C6-7, mild bilateral facet atrophy at C4-5, C5-6 and C6-7, and disc dislocation at C2-3 through C6-7. Per 01/21/15 progress report, patient's diagnosis includes cervical radiculopathy, cervical sprain/strain, lumbar radiculopathy, lumbar sprain/strain, status post surgery, right shoulder, and left shoulder impingement syndrome. Patient's medications, per 03/12/15 progress report include Tramadol, Hydrocodone, Promolactin, Omeprazole, Pentaprazole, Naproxen, Zoldem and Cyclobenzaprine. Patient's work status is modified duties. MTUS Chronic Pain Medical Treatment Guidelines, pg 22 for Anti-inflammatory medications states: Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non- selective non-steroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP. MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Treater does not discuss request. In this case, only two progress reports were provided and Naproxen was included in patient's medication in report dated 03/12/15. It is not clear how long the patient has been on this medication. However, the treater has not documented how this medication has been effective in management of pain and function. MTUS page 60 require recording of pain and function when medications are used for chronic pain. Given the lack of documentation, as required by guidelines, the request IS NOT medically necessary.

Prilosec 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors (PPIs) Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 69.

Decision rationale: The patient presents with pain in the bilateral shoulders, bilateral cervical spine pain that radiates to the trapezius and down to both arms and the median three fingers. The request is for PRILOSEC 20 MG #30. Patient is status post right rotator cuff repair, 04/2014.

Physical examination to the cervical spine on 03/12/15 revealed tenderness to palpation in all areas of the spine and trapezius muscles. Range of motion was limited in all planes with pain. Examination to the bilateral shoulders revealed diffuse tenderness over the right greater than the left shoulder bursa and anterior capsule. There was mild supraclavicular tenderness with some radiating pain down the arm. MRI findings of the cervical spine on 04/11/13 showed a 3 mm bulge at C6-7 which together with ligamentum flavum buckling results in moderate spinal stenosis, 3 mm posterior left paracentral spinal disc protrusion at C5-6 which indents the anterior thecal sac but does not result in significant spinal stenosis, 3 mm disc bulge at C3-4 which indents the anterior thecal sac but does not result in significant spinal stenosis, mild to moderate right and mild left neural foraminal narrowing at C3-4 and C4-5 mild left foraminal narrowing at C5-6 and mild to moderate bilateral neural foraminal narrowing at C6-7, mild bilateral uncovertebral spondylosis at C3-4, C4-5, C5-6 and C6-7, mild bilateral facet atrophy at C4-5, C5-6 and C6-7, and disc dislocation at C2-3 through C6-7. Per 01/21/15 progress report, patient's diagnosis includes cervical radiculopathy, cervical sprain/strain, lumbar radiculopathy, lumbar sprain/strain, status post surgery, right shoulder, and left shoulder impingement syndrome. Patient's medications, per 03/12/15 progress report include Tramadol, Hydrocodone, Promolactin, Omeprazole, Pantoprazole, Naproxen, Zoldem and Cyclobenzaprine. Patient's work status is modified duties. MTUS page 69 under NSAIDs, GI symptoms & cardiovascular risk Section states, Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 ug four times daily); or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007) Treater does not discuss request. In this case, only two progress reports were provided and Prilosec was included in patient's medication in report dated 03/12/15. It is not clear how long the patient has been on this medication. The treater does not document any gastrointestinal upset or irritation. There is no history of ulcers, either. Additionally, the patient is under 65 years of age, and there is no documented use of ASA, corticosteroids, and/or anticoagulants concurrently. The treater does not provide GI risk assessment required to make a determination based on MTUS. Therefore, the request for Prilosec 20 mg # 30 IS NOT medically necessary.