

Case Number:	CM14-0216855		
Date Assigned:	01/07/2015	Date of Injury:	12/11/2013
Decision Date:	03/04/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	12/26/2014

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:

This is a male who suffered an industrial related injury on 12/11/13. A physician's report dated 3/13/14 noted the injured worker had complaints of mid back pain that radiated to the chest, pain around the right shoulder blade, and pain to bilateral armpits. The injured worker had received a right infraspinatus trigger point injection that did not provide significant relief. The injured worker was taking a Lidoderm 5% patch and Ultram ER. The injured worker received physical therapy and acupuncture. A MRI obtained on 3/5/14 noted calf tendinitis, bursal surface fraying, glenohumeral capsulitis, and minimal degenerative changes at the AC joint. No evidence for acute muscle tear of the chest was noted. The physical examination revealed full cervical range of motion, negative bilateral Spurling sign, and no paraspinal muscle tenderness. Thoracic rotation was full but was painful in both directions. No muscle spasms were present. Right shoulder range of motion was unrestricted but painful with internal rotation. Impingement was sign was negative. A tender proximal right pectoral muscle was noted and tender bilateral axillary palpation was also noted. Diagnoses included myofascial pain of bilateral upper quadrants, thoracic strain, thoracic disk protrusion with annular tear, and right rotator cuff tendinosis. On 12/9/14 the utilization review (UR) physician denied the request for an electromyogram (EMG) of the right upper extremity, facet joint medial branch block at T7-T8 and T9-T10, Percocet 10/325mg #120, Lyrica 75mg #60, and Cymbalta 30mg #54. Regarding A EMG, the UR physician noted there did not appear to be any subtle focal neurological deficits to warrant an EMG. Regarding the medial branch block, the UR physician noted the submitted medical records failed to identify that the injured worker had significant facet mediated pain at

the T7-8 and T9-10 levels to warrant that level of intervention. Regarding Percocet, the UR physician noted the efficacy of this medication has not been documented in the medical records. Regarding Lyrica, the UR physician noted the medical records indicated the injured worker had pain that radiated into the right upper arm but did not affect neurological function. Sensation was intact and motor strength was preserved. The request was therefore non-certified. Regarding Cymbalta, the UR physician noted the injured worker did not have neuropathic pain therefore, the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of right upper extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Neck chapter, EMG

Decision rationale: This patient presents with thoracic back, bilateral sternal, right shoulder, and right axilla pain that radiates into the right upper arm. The current request is for an EMG study of the right upper extremity. The utilization review denied the request stating that there does not "appear to be any subtle focal neurological deficit for this patient to warrant the study at this time." For EMG of the upper extremities, the ACOEM Guidelines page 206 states that electrodiagnostic studies may help differentiate between CTS and other conditions such as cervical radiculopathy. The ODG guidelines Online, Cervical chapter: Electromyography (EMG) state that EMG is recommended as an option in selected cases. There is no prior EMG testing found in the medical records provided. The treating physician states that an EMG is being requested to rule out right brachial plexopathy or neuropathy. There is no indication the patient has had an EMG in the past. An EMG to establish the presence of radiculopathy is supported in the ACOEM and ODG guidelines. This request IS medically necessary.

Facet joint medial branch block at T7-T8 & T9-T10: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neck and Upper Back chapter, cervical facet joint diagnostic blocks

Decision rationale: This patient presents with thoracic back, bilateral sternal, right shoulder, and right axilla pain that radiates into the right upper arm. The current request is for fluoroscopically guided diagnostic right T7-T8 and T9-T10 facet joint medial block. The utilization review denied the request stating that "the submitted records failed to identify that this patient has

significant facet mediated pain at the T7-T8 and T9-T10 levels to warrant this level with intervention. "The ODG guidelines Neck and Upper Back chapter for cervical facet joint diagnostic blocks state that they are recommended prior to facet neurotomy and are limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. For facet joint pain, signs and symptoms the ODG guidelines state that physical examination findings are generally described as, " (1) axial neck pain (either with no radiation or rarely past the shoulders); (2) tenderness to palpation in the paravertebral areas (over the facet region); (3) decreased range of motion (particularly with extension and rotation); & (4) absence of radicular and/or neurologic findings. In this case, the patient presents with occasional radiating pain down the arm and ODG supports facet diagnostic blocks only when there is absence of radicular symptoms. This request IS NOT medically necessary.

Percocet 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

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

Decision rationale: This patient presents with thoracic back, bilateral sternal, right shoulder, and right axilla pain that radiates into the right upper arm. The current request is for Percocet 10/325 mg every 6 hours as needed #120 with no refills. For chronic opiate use, the MTUS Guidelines pages 88 and 89 state, "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. It is unclear when the patient was initially prescribed Percocet. However, progress reports dated 11/07/2014 and 12/03/2014 note Percocet as a current medication. The treating physician has stated that the patient's Oswestry Disability Index score is 32 with the use of Percocet and 40 without the use of Percocet. It was noted the patient has an up to date contract and the patient's previous UDS has been consistent. Progress reports state that the patient has no adverse side effects with medications and shows no aberrant behavior. In this case, further use of Percocet cannot be supported as the treating physician has not provided any specific functional improvement when taking this medication. There are no changes in ADL's described or change in work status to show significant functional improvement. Given the treating physician has not provided documentation of all the 4As as required by MTUS for opiate management, the requested Percocet IS NOT medically necessary.

Lyrica 75mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Page(s): 19-20.

Decision rationale: This patient presents with thoracic back, bilateral sternal, right shoulder, and right axilla pain that radiates into the right upper arm. The current request is for Lyrica 75 mg b.i.d. #60 with no refills. The MTUS guidelines pages 19-20 has the following regarding Pregabalin (Lyrica), "Pregabalin (Lyrica, no generic available) has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. In June 2007 the FDA announced the approval of pregabalin as the first approved treatment for fibromyalgia." According to progress report dated 12/03/2014, the patient is utilizing Lyrica for his continued neuropathic pain with "50% decrease in pain." Given the patient's radicular symptoms and the treating physician's documentation of this medication's efficacy, the requested Lyrica IS medically necessary.

Cymbalta 30mg #54: Overturned

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 Antiepilepsy drugs (AEDs, page 16-17) Page(s): 16-17.

Decision rationale: This patient presents with thoracic back, bilateral sternal, right shoulder, and right axilla pain that radiates into the right upper arm. The current request is for Cymbalta 30 mg #54 with no refills. For Cymbalta, the MTUS Guidelines page 16 and 17 states "duloxetine (Cymbalta) is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. It is also used for off-label neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy." It is unclear when this patient was initially prescribed this medication. According to progress report dated 12/03/2014, the patient has been utilizing Cymbalta which decreases patient's neuropathic pain by 50% and improve activities of daily living by 50%. In this case, given the patient's radicular symptoms and the documentation of this medications, efficacy, the requested Cymbalta IS medically necessary.