

<b>Case Number:</b>	CM15-0110169		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	04/26/2013
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	05/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/08/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 female, who sustained an industrial/work injury on 4/26/13. She reported initial complaints of neck, shoulder, and both elbows pain. The injured worker was diagnosed as having impingement syndrome, right shoulder biceps tendinitis, impingement syndrome of left shoulder and persistent biceps tendinitis, epicondylitis laterally, ulnar nerve dysfunction on left and right of elbow, discogenic cervical condition with shoulder girdle involvement associated with headaches, brachial plexus inflammation bilaterally with tenderness at scaline musculature. Treatment to date has included medication, physical therapy, transcutaneous electrical nerve stimulation (TENS) unit, hot wraps, surgery (left decompression and disc excision on 12/27/14, shoulder surgery on right on 5/9/13), trigger point injection. Currently, the injured worker complains of flare up of pain to neck, both shoulders, both elbows. Sleep was affected due to discomforts. Per the primary physician's progress report (PR-2) on 5/7/15, exam revealed abduction is 155 degrees bilaterally, internal rotation is 60 degrees and external rotation at 80 degrees on the right and 75 degrees on the left, tenderness along the biceps tendon on the right side and not as much on the left, impingement signs are equivocal, grade 5-strength to resist function, tenderness along the shoulder girdle musculature is noted bilaterally, neck flexion is 60 degrees, extension is 40 degrees, and tilting is 30 degrees. The requested treatments include EMG/NCV bilateral upper extremities, chiropractic treatment, physical therapy, Trigger Point, Subacromial Injection, Protonix 20mg, Neurontin 600mg, Tramadol ER 150mg, Lunesta 2mg, Psychiatry Consultation, and Four Lead TENS Unit with conductive garment.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **EMG/NCV bilateral upper extremities QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NCV (Nerve Conduction Velocity Testing).

**Decision rationale:** The request for diagnostic test EMG/NCV for bilateral upper extremities is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. The ODG further states that nerve conduction studies are 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. In this case, there is no documentation of any objective clinical findings or any neurological deficits to support the requested EMG/NCVs of the upper extremities. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.

### **Chiropractic treatment QTY: 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58 and 59.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Manual Therapy.

**Decision rationale:** According to the CA MTUS/ACOEM guidelines, Manual Therapy or Chiropractic manipulation is a treatment option during the acute phase of injury, and manipulation should not be continued for more than a month, particularly when there is not a good response to treatment. The ODG states that cervical manipulation may be a treatment option for patients with occupationally related neck pain or cervicogenic headache. The ODG recommends up to 18 total chiropractic and massage visits over 6-8 weeks for cervical and thoracic injuries with evidence of functional improvement after a 6 visit initial trial. In this case, there is documentation of 6 previous chiropractic visits. However, there is no documentation of objective functional improvement, reduction of pain score, or a decrease in medication usage. Medical necessity, for the requested 6 additional chiropractic sessions of the cervical spine, has not been established. The requested services are not medically necessary.

**Physical Therapy 12 visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58 and 59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of shoulder pain. The ODG recommends that for most patients with shoulder pain, up to 10 visits are indicated as long as functional improvement and program progression are documented; and up to 30 visits over 18 weeks for post-surgical open treatment. For rotator cuff disorders, physical therapy can improve short-term recovery and long-term function. For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopedic referral. Patients with small tears of the rotator cuff may be referred to an orthopedist after 6 to 12 weeks of conservative treatment. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, the patient has received PT for the right shoulder. However, there is no documentation of objective improvement with previous treatment. Medical necessity for the requested 12 PT sessions has not been established. The requested services are not medically necessary.

**Trigger Point QTY: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point injections Page(s): 122.

**Decision rationale:** According to California MTUS guidelines, trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: 1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; 2) Symptoms have persisted for more than three months; 3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; 4) Radiculopathy is not present on exam; 5) Not more than 3-4 injections per session; 6) No repeat injections unless greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; 7) Frequency should be at an interval less than 2 months; 8) Trigger point injections with any substance other than local anesthetic with or without steroid are not recommended. There was

no documentation provided indicating circumscribed trigger points with palpable twitch response and referred pain. In addition, there is no documentation of functional improvement following a trigger point injection in February, 2015. Medical necessity for the requested injection has not been established. The requested trigger point injection is not medically necessary.

**Subacromial Injection QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Steroid injections.

**Decision rationale:** According to the ODG, steroid injections are recommended for certain shoulder conditions. According to the medical records, this patient was noted to have pain at the tip of the left scapula and diagnosed with scapula-thoracic syndrome. Subacromial injections are useful for a range of conditions including adhesive capsulitis, sub-deltoid bursitis, and impingement syndrome. In addition, subacromial injections are effective for improvement for rotator cuff tendonitis up to a 9-month period. They are also probably more effective than NSAID medication. In this case, there is no evidence of adhesive capsulitis, impingement syndrome, or rotator cuff problems. There is no documentation of conservative treatments tried, including PT, exercise, and/or NSAIDs. The range of motion of the left shoulder is normal and there is no evidence of impingement. Medical necessity for the requested injection has not been established. The requested left subscapular bursa injection is not medically necessary.

**Protonix 20mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & cardiovascular risk Page(s): 68 and 69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

**Decision rationale:** According to CA MTUS (2009), proton pump inhibitors, such as Protonix (Pantoprazole), are recommended for patients at risk for gastrointestinal events or taking NSAIDs with documented GI distress symptoms. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. The medical necessity for Protonix has not been established. The requested medication is not medically necessary.

**Neurontin 600mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drug (AEDs) Page(s): 16-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

**Decision rationale:** According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The records do not document that the patient has neuropathic pain. In this case, there was no documentation of subjective or objective findings consistent with current neuropathic pain to necessitate use of Neurontin. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

**Tramadol ER 150mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93 and 94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 93-96.

**Decision rationale:** According to the California MTUS, Tramadol (Ultram) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Lunesta 2mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

**Decision rationale:** Lunesta (Eszopicolone) is a prescription short-acting non-benzodiazepine sedative-hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. Lunesta is indicated for the treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. According to the ODG guidelines, non-Benzodiazepine

sedative-hypnotics are considered first-line medications for insomnia. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which have potential for abuse and dependency. It appears that the non-benzodiazepines have similar efficacy to the benzodiazepines with fewer side effects and short duration of action. Lunesta has demonstrated reduced sleep latency and sleep maintenance and is recommended for short-term use. In this case, there is no documentation that the patient had a history of insomnia or sleep disturbances. Medical necessity of the requested item has not been established. The requested medication is not medically necessary.

**Psychiatry Consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2004, page127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7, p 127.

**Decision rationale:** According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity of the requested Psychiatry consultation for treatment of the patient's chronic neck pain. There is no documentation indicating that diagnostic and therapeutic management has been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

**Four Lead TENS Unit with conductive garment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, criteria for the use of TENS Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

**Decision rationale:** According to the MTUS guidelines, the TENS unit is not recommended as a primary treatment modality. A one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for conditions such as, neuropathic pain, phantom limb pain, complex regional pain syndrome (CRPS), spasticity or multiple sclerosis. In this case, there is no documentation of any objective functional benefit, a decrease of pain or decrease in medication from usage of the TENS unit. Medical necessity for the requested item has not been established. The requested TENS unit with a conductive garment is not medically necessary.