Case Number:	CM15-0036968		
Date Assigned:	03/30/2015	**Date of Injury:**	05/30/2007
Decision Date:	05/14/2015	**UR Denial Date:**	02/05/2015
Priority:	Standard	**Application Received:**	02/27/2015

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 42 year old female, who sustained an industrial injury on May 30, 2007. She reported injury of the neck, both arms, and right shoulder. The injured worker was diagnosed as having left carpal tunnel syndrome, discogenic cervical condition, ulnar nerve involvement bilaterally status post transposition with persistent symptoms. Treatment to date has included medications, work restrictions, ice applications, heat applications, and transcutaneous electrical nerve stimulation. On December 2, 2014, she has constant pain in the arm. The treatment plan includes: work restrictions, medications, completing the approved acupuncture treatment and psychiatric referral, and follow up in 4 weeks. On January 13, 2015, a PR-2 indicates continued pain in the neck, bilateral elbows, bilateral arms, bilateral wrists, and right hand. The treatment plan includes: recommendation for electromyogram, elbow splints, neck pillow and traction, trigger point injection along the shoulder blade, medications, x-ray and magnetic resonance imaging of the neck, continue acupuncture, request for physical therapy, and request for surgery. The request for authorization is for elbow pads, trigger point injection along shoulder blade, electromyogram and nerve conduction studies of bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Elbow Pad (right & left) QTY 1: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 5th Edition, 2007, Elbow Splinting.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (Acute and Chronic) / Splinting (padding).

Decision rationale: Per the MTUS/ ACOEM, "aside from surgical studies, there are no quality studies on which to rely for treatment of ulnar neuropathies, and there is not evidence of benefits of the following treatment options. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence, these treatment options are recommended: Elbow padding [Insufficient Evidence (I), Recommended]." Per the ODG, Elbow pads/ splinting is recommended for cubital tunnel syndrome (ulnar nerve entrapment), including a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from hard surfaces. A review of the injured workers medical records reveal a history of ulnar nerve entrapment with persistent symptoms despite surgical intervention and therefore based on her clinical presentation and the guidelines the request for Elbow Pad (right & left) QTY 1 is medically necessary.

Trigger Point Injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

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

Decision rationale: Per the MTUS, "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 (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended." A review of the injured workers medical records reveal objective documentation of trigger points over the trapezius bilaterally, therefore based on her complex clinical presentation and the guidelines the request for a trigger point injection along the shoulder blade is medically necessary.

EMG/NCV Right Upper Extremity QTY 1: 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 10 Elbow Disorders (Revised 2007) Page(s): 33.

Decision rationale: Per the MTUS/ ACOEM "Nerve conduction study and possibly EMG if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment". A review of the injured workers medical records reveal that she already has a diagnoses of ulnar nerve entrapment which has already been surgically managed, even though she continues to have symptoms there does not appear to be any reason to repeat the study in this case as the diagnosis has already been established. Based on this the request for EMG/NCV Right Upper Extremity QTY 1, is not medically necessary.

EMG/NCV right upper extremity: 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 10 Elbow Disorders (Revised 2007) Page(s): 33.

Decision rationale: Per the MTUS/ ACOEM "Nerve conduction study and possibly EMG if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment". A review of the injured workers medical records reveal that she already has a diagnoses of ulnar nerve entrapment which has already been surgically managed, even though she continues to have symptoms there does not appear to be any reason to repeat the study in this case as the diagnosis has already been established. Based on this the request for EMG/NCV Right Upper Extremity, is not medically necessary.

Norco 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid-pain treatment agreement.

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. On going 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 abberrant 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 medical records do not reveal subjective or objective documentation of pain or functional improvement as required by the guidelines for ongoing management and without this information medical necessity is not established.

X-rays of Neck QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

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 new red flags, surgical considerations or any of the above referenced criteria for imaging as recommended by the guidelines and therefore the request for X-Rays of The Cervical Spine is not medically necessary.

MRI Neck QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 and 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 new red flags, surgical considerations or any of the above referenced criteria for imaging as recommended by the guidelines and therefore the request for MRI neck is not medically necessary.

Elbow extension splint QTY 2: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (Acute and Chronic) / Splinting (padding).

Decision rationale: Per the MTUS/ACOEM, "aside from surgical studies, there are no quality studies on which to rely for treatment of ulnar neuropathies, and there is not evidence of benefits of the following treatment options. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence, these treatment options are recommended: Elbow padding [Insufficient Evidence (I), Recommended]." Per the ODG, Elbow pads/ splinting is recommended for cubital tunnel syndrome (ulnar nerve entrapment), including a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from hard surfaces. A review of the injured workers medical records reveal a history of ulnar nerve entrapment with persistent symptoms despite surgical intervention and therefore based on her clinical presentation and the guidelines the request for Elbow extension splint qty 2 is medically necessary.