

Case Number:	CM15-0065417		
Date Assigned:	04/13/2015	Date of Injury:	09/08/2000
Decision Date:	05/13/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/06/2015

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: Emergency 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 64 year old, male who sustained a work related injury on 9/8/2000. The diagnoses have included status post left shoulder surgeries, bilateral shoulder subacromial bursitis, right shoulder impingement, bilateral shoulder arthralgia, recurrent right carpal tunnel symptoms, right wrist degenerative joint disease, status post right carpal tunnel release, right wrist flexor tenosynovitis, and status post right wrist ganglion cyst removal with carpal tunnel revision. Treatments have included home exercises, right wrist surgery, left and right shoulder surgeries, physical therapy, heat/cold therapy, activity modifications, and medications. In the PR-2 dated 2/18/15, the injured worker complains of right wrist pain. He rates this pain a 6/10. He complains of right and left shoulder pain. He rates the pain for both shoulders a 5/10. The treatment plan is requests for updated NCV/EMG studies of upper extremities and for medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 182 and 272.

Decision rationale: EMG and NCV requested by provider are 2 different tests, testing for different pathologies. If one test is not recommended, this requested will be considered not medically necessary as per MTUS independent medical review guidelines. As per ACOEM Guidelines, Nerve Conduction Velocity Studies is not recommended for repeat 'routine' evaluation of patients for nerve entrapment. It is recommended in cases where there is a sign of median or ulnar nerve entrapment. There is no change in physical exam. Patient has chronic deficits on review of records. Patient already has a diagnosis of carpal tunnel syndrome. There is no rationale provided for requested test. NCV is not medically necessary As per ACOEM Guidelines, EMG is not recommended if prior testing, history and exam is consistent with nerve root dysfunction. EMG is recommended if pre procedure or surgery is being considered. Pt has not had any documented changes in neurological exam or complaints. There is no exam or signs consistent with radiculopathy there is no rationale about why testing is requested for a chronic condition. EMG is not medically necessary. EMG and NCV of bilateral upper extremities are not medically necessary.

Hydrocodone/APAP 10/325 mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78.

Decision rationale: Norco is acetaminophen and hydrocodone, an opioid. Patient has chronically been on an opioid pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation meets criteria. Patient has documented decrease in pain, increased objective function and appropriate monitoring or abuse or side effects. Documentation states that pt has not tolerated prior attempts to wean and patient has extensive pain issues that will not acutely improve. Continued use of Norco is medically necessary.

Cyclobenzaprine 7.5 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: Flexeril is cyclobenzaprine, a muscle relaxant. As per MTUS guidelines, evidence show that it is better than placebo but is considered a second line treatment due to high risk of adverse events. It is recommended only for short course of treatment for acute

exacerbations. There is some evidence of benefit in patients with fibromyalgia. Patient has been on this medication chronically. Despite documentation of improvement in spasm and function, chronic use of Flexeril is not recommended. Flexeril is not medically necessary.