

Case Number:	CM15-0071157		
Date Assigned:	04/21/2015	Date of Injury:	12/26/2010
Decision Date:	05/20/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/15/2015

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 52 year old female who sustained an industrial injury on 12/26/10. The injured worker reported symptoms in the bilateral hands, bilateral shoulders, neck, back and left lower extremity. The injured worker was diagnosed as having chronic myofascial pain syndrome cervical and thoracolumbar spine, worsening of pain, numbness and weakness of both hands due to cervical radiculopathy versus diabetic neuropathy versus peripheral nerve entrapment versus carpal tunnel syndrome. Treatments to date have included activity modification, physical therapy, chiropractic treatments, and epidural steroid injections. Currently, the injured worker complains of discomfort in the bilateral hands, bilateral shoulders, neck, back and left lower extremity. The plan of care was for medication prescriptions, diagnostics and braces.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Non-sedating muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: The patient presents with pain in the cervical spine, bilateral hands, bilateral shoulders, back and left lower extremity. The request is for Cyclobenzaprine 7.5mg #90. There is no RFA provided and the date of injury is 12/26/10. The diagnoses include chronic myofascial pain syndrome, cervical and thoracolumbar spine, worsening pain and numbness in both hands due to cervical radiculopathy versus carpal tunnel syndrome, pain and numbness of the bilateral upper extremities and NSAID induced gastritis. Per 02/06/15 report, physical examinations revealed multiple myofascial trigger points and taut bands throughout the cervical paraspinal, trapezius, levator scapulae, scalene, and infraspinatus muscles. The proximal muscles of the upper extremities were not tested well due to pain. Grip strength was decreased in both hands at +4/5 and dorsiflexion was decreased at -5/5 in both feet. Treatments to date have included activity modification, physical therapy, chiropractic treatments, and epidural steroid injections. Current medications include Cyclobenzaprine, Tramadol, and Omeprazole. The patient is temporarily totally disabled. MTUS pg 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." Per 02/06/15 report, treater prescribed "Cyclobenzaprine to be taken twice daily for muscle spasms (short term use per MTUS)". In this case, only one progress report was provided and prior use of cyclobenzaprine is unknown. Treater has not documented aim of use, potential benefits or side effects. MTUS Guidelines do not recommend the use of Flexeril for longer than 2-3 weeks. The request for 90 tablets indicates 4 weeks of use and exceeds guidelines. Therefore, the request is not medically necessary.

EMG/NCV bilateral lower extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Electromyography.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official disability guidelines Low Back Chapter, under Nerve conduction studies & Electrodiagnostic studies (EDS).

Decision rationale: The patient presents with chronic low back pain with left groin, hip and buttock radicular pain. The request is for EMG/NCV bilateral lower extremities. There is no RFA provided and the date of injury is 12/26/10. The diagnoses include chronic myofascial pain syndrome, cervical and thoracolumbar spine, worsening pain and numbness in both hands due to cervical radiculopathy versus carpal tunnel syndrome, pain and numbness of the bilateral upper extremities and NSAID induced gastritis. Per 02/06/15 report, physical examination of the lumbar spine revealed decreased range of motion, especially on extension, 20 degrees. There

were multiple myofascial trigger point and taut bands noted throughout the thoracic and lumbar paraspinal musculature as well as in the gluteal muscles. The patient could not perform heel-toe gait well with either foot. MRI of the lumbar spine performed on 02/11/13, revealed a 2mm posterior disc protrusion at L1-L5 causing mild narrowing of the canal at each level. Small interforaminal disc protrusions seen bilaterally at L2-3, L3-4, L4-5 resulting in bilateral neural foraminal narrowing. There is mild facet arthropathy at the L3-S1 levels bilaterally. Grip strength was decreased in both hands at +4/5 and dorsiflexion was decreased at -5/5 in both feet. Treatments to date have included activity modification, physical therapy, chiropractic treatments, and epidural steroid injections. Current medications include Cyclobenzaprine, Tramadol, and Omeprazole. The patient is temporarily totally disabled. 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." Regarding Nerve conduction studies, ODG guidelines Low Back Chapter, under Nerve conduction studies states, "not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy." ODG for Electrodiagnostic studies (EDS) states, "(NCS) which are not recommended for low back conditions, and EMGs (Electromyography) which are recommended as an option for low back." In this case, there is no reference to prior EMG or NCV and the patient continues with back pain with radicular symptoms. Per 02/06/15 report, treater states, "EMG/NCV study due to worsening of pain, numbness and weakness of both hands." Given the patient's continued complaints of pain and radicular components, further diagnostic testing may be useful to obtain unequivocal evidence of radiculopathy. Therefore, the requested EMG/NCV of the lower extremities is medically necessary.

Continue use of bilateral wrist and elbow braces: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Wrist splinting.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Carpal Tunnel Syndrome (Acute & Chronic) chapter, Splinting Elbow chapter, splinting.

Decision rationale: The patient presents with pain in the cervical spine, bilateral hands, bilateral shoulders, back and left lower extremity. The request is for continue use of bilateral wrist and elbow braces. There is no RFA provided and the date of injury is 12/26/10. The diagnoses include chronic myofascial pain syndrome, cervical and thoracolumbar spine, worsening pain and numbness in both hands due to cervical radiculopathy versus carpal tunnel syndrome, pain and numbness of the bilateral upper extremities and NSAID induced gastritis. Per 02/06/15 report, physical examinations revealed multiple myofascial trigger points and taut bands throughout the cervical paraspinal, trapezius, levator scapulae, scalene, and infraspinatus muscles. The proximal muscles of the upper extremities were not tested well due to pain. Grip strength was decreased in both hands at +4/5 and dorsiflexion was decreased at -5/5 in both feet. Treatments to date have included activity modification, physical therapy, chiropractic treatments, and epidural steroid injections. Current medications include Cyclobenzaprine, Tramadol, and

Omeprazole. The patient is temporarily totally disabled. ODG Guidelines, Carpal Tunnel Syndrome (Acute & Chronic) chapter, Splinting states: Wrist splinting after CTR: " Splinting after surgery has negative evidence. Two prospective randomized studies show that there is no beneficial effect from postoperative splinting after carpal tunnel release when compared to a bulky dressing alone. In fact, splinting the wrist beyond 48 hours following CTS release may be largely detrimental, especially compared to a home physical therapy program."ODG guidelines Elbow chapter under splinting: "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). (Apfel, 2006) (Hong, 1996) Under study for epicondylitis. No definitive conclusions can be drawn concerning effectiveness of standard braces or splints for lateral epicondylitis." In this case, only one progress report was provided and it does not include this request or discuss the patient's use of braces. ACOEM supports orthotics for epicondylar pain, and ODG recommends such conservative interventions for chronic elbow pain, for the diagnosis of cubital tunnel syndrome, which have not been documented. There is no documentation that this patient has received any bracing to date. The patient presents with numbness and tingling in the bilateral hands, which treater states is a result of cervical radiculopathy; there is no discussion of need for elbow bracing either. The request states, "Continue use of bilateral wrist and elbow braces" indicating the patient is in possession of the DME. There is no clear rationale if the request is for replacement. The purchase of bracing cannot be substantiated. The request is not medically necessary.