

<b>Case Number:</b>	CM15-0097291		
<b>Date Assigned:</b>	05/28/2015	<b>Date of Injury:</b>	06/23/2012
<b>Decision Date:</b>	06/26/2015	<b>UR Denial Date:</b>	04/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/20/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal 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 60 year old male, who sustained an industrial injury on 06/23/2012. He subsequently complained of pain in the right shoulder, right neck, upper back bilateral knees and chest. He was diagnosed with a head contusion and right shoulder, thoracic, lumbar spine and bilateral knee injuries. Treatment to date has included x-rays, medications, physical therapy, electromyography on 07/31/2012, electromyography of lower extremities on 01/29/2013, chiropractic care, MRI and right shoulder surgery. According to a progress report dated 04/03/2015, the injured worker reported low back pain that went down to the left knee and went up to the left hip. He also reported left shoulder and neck pain. He reported low back pain was worst at 9 on a scale of 1-10, neck pain at 6 that went down to the left elbow and shoulder at 7. He took Naproxen for pain and Pantoprazole with some gastrointestinal symptoms. Gabapentin helped with his symptoms. He started taking Ibuprofen when his hip pain was bad. Objective findings included 4/5 weakness of the left elbow extension, thumb and finger abduction tenderness of C5-C6 paraspinals, positive straight leg raise left supine, tenderness to L4-S1 paraspinals left and positive McMurray's left knee. Diagnoses included cervical strain/sprain, right shoulder strain status post shoulder surgery and lumbar radiculopathy, bilateral knee strain, intermittent left chest pain. Treatment plan included lumbar epidural steroid injection, EMG/NCVS (electromyography/nerve conduction velocity) studies of the left upper extremity to rule neuropathy, Relafen, Pantoprazole and follow up for shoulder and knee issues and discontinuation of Ibuprofen. Currently under review is the request for Relafen and EMG/NCV left upper extremity.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Relafen 750 mg Qty 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 22, 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, NSAI.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Relafen 750mg #60 is not medically necessary. Nonsteroidal anti-inflammatory drugs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. There appears to be no difference between traditional nonsteroidal anti-inflammatory drugs and COX-2 nonsteroidal anti-inflammatory drugs in terms of pain relief. The main concern of selection is based on adverse effects. In this case, the injured worker's working diagnoses are cervical strain/sprain; right shoulder strain, status post shoulder surgery; lumbar radiculopathy; bilateral knee strain; and intermittent chest pain. The documentation shows the injured worker, according to an April 3 2015 progress note, had complaints of low back pain radiating to the left hip in addition to left shoulder and neck pain. Objectively, motor strength is 4/5 of the left elbow, thumb and finger. There is tenderness to palpation over the C5 - C6 paraspinal muscle groups. The documentation shows the injured worker takes Naproxen and Pantoprazole. The documentation further states the injured worker also takes Ibuprofen 800 mg (in addition to naproxen). The dose of Naproxen is not present in the medical record. The treating provider now seeks to add Relafen 750mg to the medicine regimen. There is no documentation the treating provider discontinued any of the aforementioned nonsteroidal anti-inflammatory drugs (prior to requesting Relafen). There is no clinical indication or rationale for three nonsteroidal anti-inflammatory drugs taken concurrently. Consequently, absent compelling clinical documentation with a clinical indication or rationale for a third nonsteroidal anti-inflammatory drug with evidence of objective functional improvement (with prior NSAI), Relafen 750mg #60 is not medically necessary.

**EMG (electromyography)/NCV (nerve conduction velocity), Left Upper Extremity:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck and Upper Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, EMG/NCV.

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV of the left upper extremity is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identifies specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative or to differentiate radiculopathy from other neuropathies or non-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy.

While cervical electrodiagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. In this case, the injured worker's working diagnoses are cervical strain/sprain; right shoulder strain, status post shoulder surgery; lumbar radiculopathy; bilateral knee strain; and intermittent chest pain. The documentation shows the injured worker, according to an April 3 2015 progress note, had complaints of low back pain radiating to the left hip, in addition to left shoulder and neck pain. Objectively, motor strength is 4/5 of the left elbow, thumb and finger. There is tenderness to palpation at the C5 - C6 paraspinal muscle groups. Documentation, according to a June 17, 2014 progress note, states an EMG was performed on July 31, 2012 that showed abnormal study compatible with right slight sensorimotor carpal tunnel syndrome without denervation. The report was not available for review. There was no documentation indicating whether bilateral upper extremity EMGs were performed. Additionally, there are no unequivocal objective findings that identify specific nerve compromise on the neurologic examination. Consequently, absent clinical documentation with the complete EMG report from July 31, 2012 EMG with unequivocal objective evidence identifying specific nerve compromise, EMG/NCV of the left upper extremity is not medically necessary.