MAXIMUS Federal Services

| Case Number: | CM13-0010162 | | |
|---|---|---|---|
| Date Assigned: | 06/06/2014 | Date of Injury: | 01/20/2004 |
| Decision Date: | 07/30/2014 | UR Denial Date: | 07/10/2013 |
| Priority: | Standard | Application Received: | 08/12/2013 |

## 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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in Arizona. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

## CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 67 year old female with a date of injury on 1/20/2004. Diagnoses include lumbar discogenic disease with radicular pain, lateral epicondylitis, and degeneration of the hips after hip replacement. Subjective complaints are of neck and low back pain rated at 8/10 with burning and pressure. Pain can be reduced to 3-4/10 with medications. The low back pain radiated to the right thigh and on the left below the knee. Physical exam demonstrated tenderness over the cervical and lumbar paraspinal muscles, and decreased motor strength in the lower extremities. Medications include tramadol, flexeril, gabapentin, prilosec, and medrox patches.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV (Electromyography / Nerve Conduction Velocity) of the neck:** 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 8 Neck and Upper Back Complaints Page(s): 261, 269, 179, 182.

**Decision rationale:** ACOEM guidelines suggest EMG as a means of detecting physiologic insult in the upper back and neck. EMG/NCS can also be used to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection, but is not

recommended for diagnosis if history, physical, and previous studies are consistent with nerve root involvement. For shoulder complaints ACOEM does not recommend EMG/NCV for evaluation for usual diagnoses. For hand/wrist complaints EMG/NCV is recommended as appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. For this patient, subjective and objective signs/symptoms do not show evidence of nerve root involvement or carpal tunnel syndrome. Therefore, the request for EMG/NCV (Electromyography / Nerve Conduction Velocity) of the neck is not medically necessary and appropriate.

**Flexeril 7.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

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

**Decision rationale:** CA MTUS guidelines indicate that the use of cyclobenzaprine should be used as a short term therapy, and the effects of treatment are modest and may cause adverse affects. This patient had been using a muscle relaxer chronically which is longer than the recommended course of therapy of 2-3 weeks. There is no evidence in the documentation that suggests the patient experienced improvement with the ongoing use of cyclobenzaprine. Due to clear guidelines suggesting cyclobenzaprine as short term therapy and no clear benefit from adding this medication, the requested prescription for Flexeril 7.5mg #60 is not medically necessary and appropriate.

**Tramadol 50mg #120:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** The patient in question has been on chronic opioid therapy. CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, documentation shows stability on medication, increase functional ability, and no adverse side effects. Furthermore, documentation is present of MTUS opioid compliance guidelines, including risk assessment, and ongoing efficacy of medication. Therefore, the request of Tramadol 50mg #120 is medically necessary and appropriate as being consistent with guidelines.