

<b>Case Number:</b>	CM13-0025724		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	10/30/2002
<b>Decision Date:</b>	11/07/2014	<b>UR Denial Date:</b>	09/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2013

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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:

Medical records reflect the claimant is a 54 year old female who sustained a work injury on 10-30-02. Office visit on 8-26-13 notes the claimant was referred to internal medicine for management of diabetes, hypertension and NSAID gastropathy, as well as referral to psychiatrist. It is noted the claimant needs a CPAP machine. The claimant is provided with a prescription for Gabapentin and Savella.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **ELECTROMYOGRAM (EMG) LUMBAR SPINE AND BILATERAL LOWER EXTREMITIES: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Special Studies and Diagnostic And Treatment Consideration Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter - EMG

**Decision rationale:** ACOEM guidelines reflect that Needle EMG is recommended when a spine Computerized Tomography (CT) or MRI is equivocal and there are ongoing pain complaints that

raise questions about whether there may be an identifiable neurological compromise. This includes extremity symptoms consistent with radiculopathy, spinal stenosis, peripheral neuropathy, etc. EMG is not recommended for claimants with subacute or chronic spine pain who do not have significant arm or leg pain, paresis or numbness. There is an absence in objective documentation to support a suspicion of a nerve entrapment. Therefore, the medical necessity of this request is not established.

**NERVE CONDUCTION VELOCITY (NCV) LUMBAR SPINE AND BILATERAL LOWER EXTREMITIES: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: [http://www.odg-twc.com/odgtwc/low\\_back.htm](http://www.odg-twc.com/odgtwc/low_back.htm)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NCS Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter - NCS

**Decision rationale:** ODG reflects that NCS 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-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a claimant is already presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) (Lin, 2013) While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. There is an absence in objective documentation to support a suspicion of a nerve entrapment. Therefore, the medical necessity of this request is not established.

**FUNCTIONAL CAPACITY EVALUATION LUMBAR SPINE AND CERVICAL SPINE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-FCE

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines FUNCTIONAL IMPROVEMENT MEASURES Page(s): 48.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines reflect that functional improvement measures are indicated as objective measures of the patient's functional performance in the clinic (e.g., able to lift 10 lbs floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient self-assessment of functional status through the use of questionnaires, pain scales, etc (Oswestry, DASH, VAS, etc.) Physical Impairments (e.g., joint Range of Motion (ROM), muscle flexibility, strength, or

endurance deficits): Include objective measures of clinical exam findings. ROM should be in documented in degrees. Approach to Self-Care and Education Reduced Reliance on Other Treatments, Modalities, or Medications: This includes the provider's assessment of the patient compliance with a home program and motivation. The provider should also indicate a progression of care with increased active interventions (vs. passive interventions) and reduction in frequency of treatment over course of care. (California, 2007) For chronic pain, also consider return to normal quality of life, e.g., go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life. (Cowan, 2008). This claimant is note to be totally temporarily disabled. There is an absence in documentation noting how the results of this test will be used to manage her care/change her current treatment. Therefore, the medical necessity of this request is not established.

### **CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) MACHINE PURCHASE:**

Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.cms.hhs.gov/manuals/pub06pdf/pub06pdf.asp>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.entnet.org/content/continuous-positive-airway-pressure-cpap>

**Decision rationale:** US National Library of medicine notes that CPAP, or continuous positive airway pressure, is a treatment that uses mild air pressure to keep the airways open. CPAP typically is used by people who have breathing problems, such as sleep apnea. There is an absence in documentation noting objective findings of sleep apnea. Therefore, the medical necessity of this request is not established.