

<b>Case Number:</b>	CM13-0048974		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	02/26/2004
<b>Decision Date:</b>	04/28/2014	<b>UR Denial Date:</b>	10/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2013

### 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 Interventional Medicine and is licensed to practice in District of Columbia and Virginia. 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:

This is a 53 year old patient who sustained injury on Feb 26 2004 and developed chronic cervicalgia, thoracic and lumbar pain, recurrent myofascial pain and referred pain in all the extremities. The physician saw the patient on Sept 26 2013 for mid back and neck pain. He was diagnosed with lumbar radiculopathy and was status post cervical decompression fusion at C5-6 and C6-7. It was recommended that the patient take: Norco 10/325 mg one po every 4 hours prn, Lyrica 150mg one po bid, Tramadol 50mg every 12 hr prn, Zanaflex 4mg one po every 8-12h prn. Also, it was advised for patient to have an epidural steroid injection at C4-5, CT scan of the cervical spine to evaluate pseudoarthrosis, EMG/NCS of the bilateral upper and lower extremities, and urine toxicology screening. The physician saw the patient on Dec 7 2012 for back and neck pain. He was diagnosed chronic pain and was status post cervical decompression fusion at C5-6 and C6-7. It was recommended that the patient take: Norco 10/325 mg one po every 4 hours prn, Lyrica 75 mg one po bid, Tramadol 50mg every 12 hr prn, Medrox patch prn. The physician saw the patient on Jan 25 2013 for low back pain and recommend a CT scan of the cervical spine and follow up.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **ELECTROMYOGRAPHY (EMG) OF THE BILATERAL LOWER EXTREMITIES:**

Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Upper back -EMG

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Upper back -EMG.

**Decision rationale:** Per ODG, it is recommended as an option(needle, not surface). EMGs(electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1 month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious.(Bigos 1999)(Ortiz-Corredor 2003)(Haig 2005). No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis.(Dimonopoulos 2004) EMG's may be required by the AMA guides for impairment rating of radiculopathy. Note: EMG Needl and H-reflex tests are recommended but Surface EMG and F-wave tests are not very specific and not recommended. The patient has documented signs and clinical history to show an established radiculopathy and further testing will not alter diagnosis and is not needed.

## **ELECTROMYOGRAPHY (EMG) OF THE BILATERAL UPPER EXTREMITIES:**

Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lower Back EMG.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lower Back EMG.

**Decision rationale:** Per ODG, EMG is recommended (needle , not surface) is recommended as an option in selected cases. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive(50%-71%) and highly specific(65%-85%). Indications when particularly helpful: EMG may be helpful for patients with double crush phenomenon, in particular, when there is evidence of possible metabolic pathology such as neuropathy secondary to diabetes or thyroid disease or evidence of peripheral compression such as carpal tunnel syndrome. H-reflex: technically difficult to perform in the upper extremity but can be derived from the median nerve. The test is not specific for etiology and may be difficult to obtain in obese patients or those older than 60 years of age. (Negrin 1991)(Alrawi 2006)(Ashkan 2002)(Nardin 1999)(Tsao 2007) See Discectomy-laminectomy-laminoplasty. (Surface EMG and F-wave tests are not very specific and therefore are not recommended. For more information on surface EMG, see the Low Back Chapter).The patient has documented signs and clinical history to show an established radiculopathy and further testing will not alter diagnosis and is not needed.

**NERVE CONDUCTION STUDIES (NCS) OF THE BILATERAL LOWER EXTREMITIES: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Upper back -EMG.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Upper back -EMG.

**Decision rationale:** Per ODG, Nerve conduction studies(NCS) are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy.(Utah 2006) While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy but these studies can result in unnecessary over treatment(Plasteras 2011)(Lo 2011)(Fuglsang-Frederiksen 2011). See also Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. The patient has documented signs and clinical history to show an established radiculopathy and further testing will not alter diagnosis and is not needed.

**NERVE CONDUCTION STUDIES (NCS) OF THE BILATERAL UPPER EXTREMITIES: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Upper back -EMG.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Upper back -EMG.

**Decision rationale:** Per ODG, Nerve conduction studies(NCS) are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy.(Utah 2006) While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy but these studies can result in unnecessary over treatment(Plasteras 2011)(Lo 2011)(Fuglsang-Frederiksen 2011). See also Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. The patient has documented signs and clinical history to show an established radiculopathy and further testing will not alter diagnosis and is not needed.

**TRAMADOL 50MG#60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-79.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 80, 83-84.

**Decision rationale:** Per MTUS guidelines for Tramadol: A recent Cochrane review found that this drug decreased pain intensity, produced symptom relief and improved function for a time period of up to three months but the benefits were small (a 12% decrease in pain intensity from baseline). Adverse events often caused study participants to discontinue this medication, and could limit usefulness. There are no long-term studies to allow for recommendations for longer than three months. (Cepeda, 2006) Similar findings were found in an evaluation of a formulation that combines immediate-release vs. extended release Tramadol. Adverse effects included nausea, constipation, dizziness/vertigo and somnolence. (Burch, 2007). This patient, in addition to Tramadol, was taking another narcotic called Norco. Both of these agents are short acting and it is not medically indicated to take two of similar agents simultaneously.

**ZANAFLEX 4MG # 60:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

**Decision rationale:** Per MTUS guidelines, Tizanidine (Zanaflex®), generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007) Side effects: somnolence, dizziness, dry mouth, hypotension, weakness, hepatotoxicity (LFTs should be monitored baseline, 1, 3, and 6 months). (See, 2008) Dosing: 4 mg initial dose; titrate gradually by 2 - 4 mg every 6 - 8 hours until therapeutic effect with tolerable side-effects; maximum 36 mg per day. (See, 2008) Use with caution in renal impairment; should be avoided in hepatic impairment. Tizanidine use has been associated with hepatic aminotransaminase elevations that are usually asymptomatic and reversible with discontinuation. The patient was diagnosed with myofascial pain which was recurrent. Per MTUS, zanaflex would be indicated and is medically indicated.