

<b>Case Number:</b>	CM13-0065968		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	09/11/2012
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	12/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/13/2013

### 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 North Carolina. 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:

The patient is a 53-year-old with a reported date of injury of 09/11/2012. The patient has the diagnoses of chronic neck and back pain, bilateral knee arthralgia, bilateral hand arthralgia and cervical/lumbar radiculopathies. Per the only progress notes provided for review from the primary treating physician dated 11/168/2013, the patient had complaints of continued neck and back pain rated a 8/10 with radiation of the pain in both the upper and lower extremities. The physical exam noted tenderness in the cervical and thoracic paraspinal muscles and the lower lumbar facet regions bilaterally. There was restricted lumbar and cervical range of motion. There was hyperesthesia in the right C7/C8 dermatome and no deficits in the lower extremities. The treatment plan recommendations included MRI of the cervical, thoracic and lumbar spine, orthopedic consult, continue chiropractic care and continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **EMG 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)- TWC Neck & Upper Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** The ACOEM chapter on neck and upper back complaints and EMG/NCV states: Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided progress notes show only hyperesthesia in the C7 and C8 dermatome on the right with no other neurologic findings. There is no mention of any left sided pathology or nerve dysfunction nor is there any physical findings recorded on the right upper extremity. In the absence of any recorded right sided abnormalities, the need for bilateral upper extremity EMG/NCV has not been established or criteria met as outline above per the ACOEM. Therefore the request is not medically necessary.

**NCS 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)- TWC Neck & Upper Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** The ACOEM chapter on neck and upper back complaints and EMG/NCV states: Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT]

for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided progress notes show only hyperesthesia in the C7 and C8 dermatome on the right with no other neurologic findings. There is no mention of any left sided pathology or nerve dysfunction nor is there any physical findings recorded on the right upper extremity. In the absence of any recorded right sided abnormalities, the need for bilateral upper extremity EMG/NCV has not been established or criteria met as outline above per the ACOEM. Therefore the request is not medically necessary.

**EMG 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)- TWC Low Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**Decision rationale:** The ACOEM section on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The provided documentation makes no mention of any sensory or neurologic deficits in the lower extremity physical exam. The patient does have pain radiating to the lower extremity but evidence of neurologic dysfunction on physical exam. Therefore the request is not medically necessary.

**NCS 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)- TWC Low Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**Decision rationale:** The ACOEM section on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The provided documentation makes no mention of any sensory or neurologic deficits in the lower extremity physical exam. The patient does have pain radiating to the lower extremity but evidence of neurologic dysfunction on physical exam. Therefore the request is not medically necessary.

**Lab Work:** 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)- TWC Pain Procedure Summary.

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

**Decision rationale:** The California MTUS and ACOEM do not specifically address the requested service. The Official Disability Guidelines section on fasting blood work does recommend blood work for the diagnosis of diabetes. Specific blood work would also be indicated in the evaluation of various other disease states. The request makes no specification of what type of blood work or the indications for the blood work. In the absence of any such documentation for this, the request is not medically necessary.

**Lidopro Topical ointment 4 oz:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The California chronic pain medical treatment guidelines section on topical analgesics states:Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka,

2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains several components that are not recommended as topical analgesics per the California MTUS. This includes menthol and methyl salicylate. Per the guideline recommendations, if a compounded agent contains one component that is not recommended, then the entire combination product is not recommended. For these reasons the requested medication does not meet guideline recommendations. Therefore the request is not medically necessary.