

<b>Case Number:</b>	CM14-0106515		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	10/23/2013
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	06/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2014

### 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 California. 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 injured worker is a 28-year-old female who reported an injury on 10/23/2013. The mechanism of injury was not provided. The injured worker's diagnoses include right strain/shoulder, lumbosacral/joint/ligament sprain/strain, and cervical sprain/strain. The injured worker's past treatments included medications, a home exercise program, TENS unit, and chiropractic sessions. The injured worker's diagnostic testing included official MR of the thoracic spine and official MR of the lumbar spine on 02/20/2014. The injured worker's surgical history was not provided. The clinical note dated 06/17/2014, the injured worker complained of neck/upper back pain rated 5/10, right shoulder pain rated 7/10, and low back pain rated 9/10. The injured worker had decreased range of motion in the lumbar area, tenderness to palpation in the thoracic and lumbar spine. The injured worker's medications include Norco 5/325 mg 1 and one half tablets 2 to 3 times a day as needed, ketoprofen 75 mg daily, and cyclobenzaprine 10 mg at bedtime and twice a day as needed. The medical records indicate the pain decreases to 5/10 to 6/10 with the medications and increases to 10/10 without. The medications improve activities of daily living and functionality, and no side effects for medications or drug seeking behavior is noted. The request was for EMG/NCV for the bilateral upper extremities and bilateral lower extremities, Norco 5/325 mg, and cyclobenzaprine 10 mg. The rationale for the request was not provided. The request for authorization form was not submitted for review.

### 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 Upper Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back: Electromyography (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 and Upper Back, EMG

**Decision rationale:** The request for electromyography (EMG) of the bilateral upper extremities is not medically necessary. The injured worker is diagnosed with right strain of the shoulder, lumbosacral joint ligament sprain/strain, and cervical sprain/strain. The injured worker complains of neck and upper back pain 5/10, right shoulder pain 7/10, and low back pain 9/10. The Official Disability Guidelines recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS (complex regional pain syndrome) II causalgia. EMG and NCS are separate studies and should not necessarily be done together. In the Low Back Chapter and Neck Chapter, it says NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards: EDX testing should be medically indicated. Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than a diagnosis are not acceptable. The number of tests performed should be the minimum needed to establish an accurate diagnosis. NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. The medical records do not indicate that range of motion was performed on the upper extremities. There was a lack of significant physical examination findings which demonstrate neurologic deficits in the upper extremities. As such, the request for electromyography (EMG) of the bilateral upper extremities is not medically necessary.

## **Nerve Conduction Velocity (NCV) Test of the Bilateral Upper Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back: Nerve conduction studies (NCS)

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

**Decision rationale:** The request for nerve conduction velocity (NCV) of the bilateral upper extremities is not medically necessary. The injured worker is diagnosed with right strain of the shoulder, lumbosacral/joint/ligament sprain/strain, and cervical sprain/strain. The injured worker complained of neck and upper back pain rated 5/10, right shoulder pain rated 7/10, and low back pain rated 9/10. The Official Disability Guidelines recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II causalgia. EMG and NCS are separate studies and should not necessarily be done together. In the Low Back Chapter and Neck Chapter, it says NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards: EDX testing should be medically indicated. Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable. The number of tests performed should be the minimum needed to establish an accurate diagnosis. NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. The medical records do not indicate that range of motion was performed on the upper extremities. There was a lack of significant physical examination findings which demonstrate neurological deficit in the upper extremities. As such, the request for nerve conduction velocity test (NCV) of the bilateral upper extremities is not medically necessary.

## **Electromyography (EMG) of the Bilateral Lower Extremities: Upheld**

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

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

**Decision rationale:** The request for electromyography (EMG) of the bilateral lower extremities is not medically necessary. The injured worker is diagnosed with right strain of the shoulder, lumbosacral joint ligament sprain/strain, and cervical sprain/strain. The injured worker complains of neck and upper back pain rated 5/10, right shoulder pain rated 7/10, and low back pain rated 9/10. The Official Disability Guidelines recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II causalgia. EMG and NCS are separate studies and should not necessarily be done together. In the Low Back Chapter and Neck Chapter, it says NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards: EDX testing should be medically indicated. Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable. The number of tests performed should be the minimum needed to establish an accurate diagnosis. NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. The medical records do not indicate that range of motion was performed on the lower extremities. The injured worker did not have documentation of a straight leg raise test to have been performed bilaterally. There was a lack of significant physical examination findings which demonstrate neurological deficit in the lower extremities. As such, the request for electromyography (EMG) of the bilateral lower extremities is not medically necessary.

## **Nerve Conduction Velocity (NCV) Test 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, Low Back: Nerve conduction studies (NCS)

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

**Decision rationale:** The request for nerve conduction velocity (NCV) of the bilateral lower extremities is not medically necessary. The injured worker is diagnosed with right strain of the shoulder, lumbosacral/joint/ligament sprain/strain, and cervical sprain/strain. The injured worker complains of neck and upper back pain rated 5/10, right shoulder pain rated 7/10, and low back pain rated 9/10. The Official Disability Guidelines recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II causalgia. EMG and NCS are separate studies and should not necessarily be done together. In the Low Back Chapter and Neck Chapter, it says NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards: EDX testing should be medically indicated. Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable. The number of tests performed should be the minimum needed to establish an accurate diagnosis. NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. The medical records did not indicate that range of motion was performed on the lower extremities. The injured worker had a lack of documentation of a straight leg raise to have been performed bilaterally. There is a lack of significant physical examination findings which demonstrate neurological deficit in the lower extremities. As such, the request for nerve conduction velocity test (NCV) of the bilateral lower extremities is not medically

necessary.

**Norco 5/325mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen, Opioids, Weaning of Medications Page(s).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOID MANAGEMENT Page(s): 78.

**Decision rationale:** The request for Norco 5/325mg, #60 is not medically necessary. The injured worker is diagnosed with right strain of the shoulder, lumbosacral/joint/ligament sprain/strain, and cervical sprain/strain. The injured worker complains of neck and upper back pain rated 5/10, right shoulder pain rated 7/10, and low back pain rated 9/10. The injured worker states pain decreases to 5/10 to 6/10 with medications and increases to 10/10 without medications, allows activities of daily living and functionality, denies side effects from medications or drug seeking behavior. The California MTUS Guidelines recommend an ongoing review of medications with documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend that opioids for chronic back pain be limited for short term pain relief not greater than 16 weeks. The injured worker has been prescribed Norco 5/325 since at least 04/23/2014. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. The documentation did not include a recent urine drug screen. Additionally, the request does not indicate the frequency of the medication. As such, the request for Norco 5/325mg, #60 is not medically necessary.

**Cyclobenzaprine 10mg, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-66.

**Decision rationale:** The request for cyclobenzaprine 10mg, #30 is not medically necessary. The injured worker is diagnosed with right strain of the shoulder, lumbosacral joint ligament sprain/strain, and cervical sprain/strain. The injured worker complains of neck and upper back pain rated 5/10, right shoulder pain rated 7/10, and low back pain rated 9/10. The California MTUS Guidelines recommend non-sedating muscle relaxants with causation as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility. Flexeril is recommended for a short course of therapy. This medication is not recommended to be used longer than 2 to 3 weeks. The injured worker has been prescribed cyclobenzaprine since at least 01/27/2014, which exceeds the guidelines' recommended 2 to 3 weeks. There is a lack of documentation of the efficacy of the medication regimen, the timeframe of efficacy, and the efficacy of functional status that the medication provided. Additionally, the request does not indicate the frequency of the medication. As such, the request for cyclobenzaprine 10mg, #30 is not medically necessary.