

<b>Case Number:</b>	CM14-0165250		
<b>Date Assigned:</b>	10/10/2014	<b>Date of Injury:</b>	08/01/2013
<b>Decision Date:</b>	11/28/2014	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2014

### 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 Internal Medicine 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 60-year-old male who reported an injury on 08/01/2013. The mechanism of injury was not submitted for review. The injured worker has diagnoses of headaches, cervicgia, rule out cervical disc displacement, radiculopathy of the cervical region, thoracic spine pain, rule out thoracic disc displacement, low back pain, lumbar disc displacement, radiculopathy of the lumbar region, sprain of unspecified ligament of ankle bilaterally, rule out joint derangements of bilateral ankles, anxiety and stress. Past medical treatment consists of physical therapy, chiropractic therapy, the use of a TENS unit, and medication therapy. Medications include Deprizine, Dicopanol, Comtrex, Synapryn, Tabradol, Cyclobenzaprine, and Ketoprofen cream. An MRI obtained 03/17/2014 of the thoracic spine revealed left lateral scoliosis of the upper thoracic spine. The vertebral body heights were maintained. The signal and caliber of the spinal cord was within normal limits. There was no evidence of an occult fracture. The vertebral body heights and neural signal were normal with normal alignment. No dislocation or fracture were visualized. Early disc desiccation was noted at upper and mid thoracic spine levels. Schmorl's nodes were noted at T10 through T11 and T11 through T12 levels. On 08/21/2014, the injured worker complained of neck and back pain. It was noted on physical examination that the injured worker had a pain rate of 6/10 to 7/10. It was noted on physical examination that sensation to pinprick and light touch were slightly diminished over the C5, C6, C7, C8, and T1 dermatomes in the bilateral upper extremities. Myotomes C5, C6, C7, C8, and T1 were decreased secondary to pain in the bilateral upper extremities. Examination of the thoracic spine revealed palpable tenderness over the spinous process T1 through T6. There was also bilateral thoracic paraspinal muscle guarding. Range of motion revealed a flexion of 30 degrees, extension of 20 degrees, left rotation of 40 degrees, and right rotation of 55 degrees. Kemp's test was positive bilaterally. Examination of the lumbar spine revealed that the injured

worker had tenderness to palpation +2 at the spinous process at L2 to L5. There was also bilateral lumbar paraspinal guarding. Range of motion revealed a flexion of 35 degrees, extension of 25 degrees, left lateral flexion of 15 degrees, and left/right lateral flexion of 10 degrees. Straight leg raise was positive at 65 degrees bilaterally, and sitting roots were positive bilaterally. The medical treatment plan is for the injured worker to undergo NCV/EMG of the upper and lower extremities, consult with pain management, continue the use of a TENS unit, and continue with chiropractic manipulation. The rationale and Request for Authorization form were not submitted for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**NCV/EMG of the upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for NCV/EMG of the upper extremities is not medically necessary. California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H reflex test, may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. The submitted documentation indicated that the injured worker had cervical pain. It was noted on physical examination that the injured worker had sensation to pinprick and light touch diminished over the C5, C6, C7, C8, and T1 dermatomes in the bilateral upper extremities. It was also noted on physical examination that myotomes C5, C6, C7, C8, and T1 were decreased secondary to pain in the bilateral upper extremities. However, it was not indicated in the submitted documentation how the provider felt an NCV/EMG would provide a role in the treatment of the injured worker. Additionally, it was not indicated in the submitted documentation as to how long the injured worker was having this type of pain. Given the above, the injured worker is not within recommended guidelines. As such, the request is not medically necessary.

**NCV/EMG of the 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 Official Disability Guidelines

**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 Chapter, Nerve conduction studies (NCS).

**Decision rationale:** The request for NCV/EMG of the lower extremities is not medically necessary. ODG guidelines do not recommend NCS as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. There is no documentation of peripheral neuropathy condition that exists in the bilateral lower extremities. There is no documentation specifically indicating the necessity for both an EMG and NCV. In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. The submitted MRI dated 03/17/2014 of the lumbar spine revealed normal lordotic curvature. There was no evidence of occult fracture. The vertebral body heights and marrow signal were normal. There was no destructive bony lesion. The conus medullaris terminated at L1 and was normal in appearance. The distal spinal cord and cauda equina were normal. The paraspinal soft tissues were unremarkable. Disc desiccation was noted throughout the lumbar spine. However, the provider failed to submit a rationale to necessitate an additional diagnostic study, NCV/EMG of the lower extremities. As it is not recommended per the ODG, the request for an NCV/EMG of the lower extremities is not medically necessary.

**Pain Management Consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, 4/27/2007 page 56

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

**Decision rationale:** The request for Pain Management Consultation is not medically necessary. The ODG states that determination of an evaluation is based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As evidence by the report submitted for review there was no indication of the injured worker taking any opioids or antibiotic. As evidenced by the report submitted for review, there was no indication of the injured worker taking any opioids or antibiotics. The determination of necessity of an office visit that requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. There was no documented evidence showing as to how a pain management evaluation would benefit any functional deficits the injured worker may have. Given the above, the injured worker is not within ODG criteria. As such, the request is not medically necessary.

**TENS unit for home use:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116.

**Decision rationale:** The request for TENS unit for home use is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that there must be documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed and other ongoing pain treatment should also be documented during the trial period including medication usage. MTUS also states that a TENS unit is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, that the patient has medical conditions (such as skin pathology) that prevents the use of the traditional system, or the TENS unit is to be used under a cast (as in treatment for disuse atrophy). The proposed necessity of the unit should be documented upon request. Rental would be preferred over purchase during this 30-day period. Given the above guidelines, the injured worker is not within the guidelines for the purchase of a TENS unit. There was lack of documentation of the injured worker's pain for at least 3 months. There was also no evidence submitted for review of the injured worker's past treatment with a TENS unit. Additionally, there was no documentation of conservative care or with therapy attempted and failed. Furthermore, the guidelines stipulate that an initial trial of a TENS unit be a rental for a time period of 30 days with proper documentation of proposed necessity. The submitted documentation did not indicate how many days the injured worker had already used the TENS unit and whether it was an initial trial. Furthermore, the request as submitted did not indicate whether the TENS unit was for rental or for purchase. Given the above, the injured worker is not within recommended guidelines. As such, the request is not medically necessary.

**TENS Unit supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116.

**Decision rationale:** As the primary service is not supported, this associated service is also not supported.