

<b>Case Number:</b>	CM14-0179448		
<b>Date Assigned:</b>	11/03/2014	<b>Date of Injury:</b>	07/19/2009
<b>Decision Date:</b>	02/06/2015	<b>UR Denial Date:</b>	10/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2014

### 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 (IW) is a 46-year-old man with a date of injury of July 19, 2009. The mechanism of injury occurred when a 300 to 500 pound doorbell on the IW and struck him in the cervicthoracic junction. He then fell to the ground under the door and was pinned to the floor. The injured worker's working diagnoses are chronic pain syndrome; myalgia; dysthymic disorder; pain in joint, lower leg; degeneration of lumbar or lumbosacral intervertebral disc; low back pain; degenerative disc disease, cervical; cervicalgia; lumbar radiculitis, bilateral at L5-S1; and chondromalacia of left patella per MRI dated 9/22/09. Pursuant to the sole primary Treating Physician's Progress Report (PR-2) dated November 25, 2014, the IW presents for a 4-week follow-up regarding his low back pain. He has a thoracic epidural steroid injection (ESI) on September 23, 2014. He reports more than 50% pain relief. He has not had a flare-up of low back pain since the ESI. He reports medication are helping and allow for increased function. He reports the pain is 7/10 with pain medications. The pain is described as aching in the mid and upper back. Medications include Norco, Naproxen, Tizanidine, Butrans patch, Lidoderm patch, Gabapentin, and Sertraline. Documentation in the November 20, 2014 QME indicated the IW has been taking Naproxen since 2009. There are no pain assessments or evidence of objective functional improvement associated with the long-term use of Naproxen. Examination of the thoracolumbar spine reveals 5/5 bilateral lower extremity strength. Sensation is intact but decreased over his left anterolateral thigh. Sacroiliac joints are non-tender. There is tenderness over the thoracic and lumbar paraspinals. There is increased tenderness to palpation over T7-T8. There is pain with lumbar flexion and extension. Straight leg raise elicits low back pain. MRI of the lumbar spine dated September 26, 2014 showed at L4-L5, a small tear in the posterior fibers of the annulus. There is slight posterior bulging of the disc but no underlying nerve root displacement or entrapment is seen. The neural foramen appears patent. At L5-S1, there is slight

posterior bulging disc contouring the epidural fat, but not displacing the underlying nerves. The neural foramen appears mildly narrowed bilaterally. The IW continues to complain of increased neuropathic pain radiating from his low back down his left lower extremity. EMG dated September 29, 2009 showed chronic irritation of bilateral L5-S1 nerve roots; and changes in lumbar paraspinals. According to documentation provided by the QME dated November 20, 2014, the provider reports the IW has significant signs of neuropathy such as atrophy, positive EMG findings and the straight leg raise finding. The current request is for EMG/NCV of the bilateral lower extremities, and Naproxen 550mg #60.

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

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

**Electromyogram/nerve conduction study (EMG/NCS) of the bilateral lower extremities (BLE):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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/NCV.

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV bilateral lower extremities is not medically necessary. Nerve conduction studies 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. EMG may be useful to obtain unequivocal evidence of radiculopathy, after one month conservative therapy, but are not necessary if radiculopathy is already clinically obvious. In this case, the injured worker's working diagnoses are chronic pain syndrome; myalgia; dysthymic disorder; pain in joints, lower leg; degeneration of lumbosacral intervertebral disc; low back pain; degenerative disc disease, cervical; cervicgia; lumbar radiculitis, bilateral L5 and S1; and chondromalacia left patella. The documentation indicates the injured worker has a left lower extremity clinical radiculopathy. Pain radiates from the lower back into the left leg. In 2009, the injured worker had an EMG/NCV of the lower extremities. The results showed chronic irritation of the bilateral L5 - S1 nerve roots. An MRI was performed on September 23, 2014. There were no significant findings. The guidelines indicate there was minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. Despite the guidelines, the injured worker underwent EMG/NCV in 2009. There was chronic irritation of the bilateral L5 - S1 nerve roots. The recent documentation does not provide a clinical indication or rationale to repeat the EMG/NCV. Consequently, absent the appropriate clinical indications/rationale to repeat EMG/NCV contravention of the guideline recommendations, EMG/NCV bilateral lower extremities is not medically necessary.

**Naproxem 500 mg, sixty count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAI Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back, EMG/NCV.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Naproxen 500 mg #60 is not medically necessary. Nonsteroidal anti-inflammatory drugs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. In this case, the injured worker's working diagnoses are chronic pain syndrome; myalgia; dysthymic disorder; pain in joints, lower leg; degeneration of lumbosacral intervertebral disc; low back pain; degenerative disc disease, cervical; cervicalgia; lumbar radiculitis, bilateral L5 and S1; and chondromalacia left patella. The documentation indicates the injured worker has a left lower extremity clinical radiculopathy. Pain radiates from the lower back into the left leg. The documentation indicates the injured worker was taking Naproxen 500 mg since 2009. There were two notes in the medical record. One was a qualified medical examination (QME) and the other was a progress note dated November 25, 2014. The QME stated Naproxen 500mg was being used by the injured worker since 2009. The progress note dated November 25, 2014 indicates the injured worker was still taking Naproxen 500 mg. The medical record did not contain documentation indicating objective functional improvement regarding nonsteroidal anti-inflammatory drug use. Consequently, absent the appropriate clinical documentation containing objective functional improvement to support the ongoing use of nonsteroidal anti-inflammatory drugs and the guideline recommendations indicating the lowest dose for the shortest period, Naproxen 500 mg #60 is not medically necessary.