

Case Number:	CM14-0198075		
Date Assigned:	01/07/2015	Date of Injury:	06/11/2013
Decision Date:	04/13/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	11/25/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Pennsylvania
 Certification(s)/Specialty: Internal Medicine

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 39 year old woman sustained an industrial injury on 6/11/2013. Diagnoses include lumbago, displacement of lumbar intervertebral disc, lumbar radiculopathy, myalgia, shoulder tendinitis, meniscal tear of knee, cervical disc protrusion, depression, headache, and hypertension. Treatment has included medications and epidural steroid injections. The Utilization Review determination also notes prior shockwave therapy and acupuncture, although discussion and reports of these treatments were not present in the records submitted. Magnetic resonance imaging (MRI) of the thoracic spine on 10/22/13 showed early spondylitic changes. MRI of the right knee on 10/22/13 showed ganglion/synovial cyst in the popliteal fossa, bone bruise/contusion of the medial femoral condyle, Wiberg type 2 patella showing lateral subluxation, and small knee joint effusion. MRI of the right knee on 10/22/13 showed chronic tear in the lateral meniscus, ganglion/synovial cyst in the popliteal fossa, degenerative arthritis, and small effusion. MRI of the lumbar spine on 10/22/13 showed disc protrusions at L3-4, L4-5 and L5-S1 with unremarkable exiting nerve roots. MRI of the cervical spine on 12/31/13 showed disc protrusions at C4-5, C5-6, C 6-7 with some degenerative changes and stenosis and some contact/deviation of the exiting nerve roots, with intact C4, C5, C6 and C7 exiting nerve roots. Progress notes from 8/22/14 and 10/15/14 were submitted. Physician notes on a PR-2 dated 10/15/2014 show multiple requests for various therapies. The documentation noted pain in the cervical, thoracic, and lumbar spine and in bilateral knees and ankles, numbness and tingling of the upper and lower extremities, increased pain with activities of daily living and decreased pain with medications. Symptoms of depression were noted. Examination showed trapezius muscle

tenderness and negative straight leg raising. Diagnoses included cervical and lumbar spine disc protrusion, shoulder tendinitis, meniscal tear of knee, depression, headache, and hypertension. Work status was noted as off work. On 11/18/2014, Utilization Review non-certified requests for for EMG with somatosensory bilateral upper extremities (from 8/22/2014 report) and EMG bilateral upper extremities with somatosensory (from 8/22/2014 report), EMG bilateral lower extremities (from 10/15/2014 report), creams prescribed per report of 8/22/14, flurbiprofen 20%/ baclofen 10%,/dexamethasone 2%in cream base 210 grams, omeprazole 20 mg #30 (from 8/22/2014 report) and omeprazole 20mg #30 (from 10/15/2014 report), cyclobenzaprine 5 mg #90 (from 8/22/2014 report) and cyclobenzaprine 5mg #30 (from 10/15/2014 report); urinalysis performed 10/15/2014, pain management evaluation, internal medicine consultation for headaches (from 8/22/2014 report) and internal medicine consultation for headaches (from 10/15/2014 report), shockwave therapy 1-2 x/week for four weeks to ankles, shoulders, knees, leg, neck, thoracic, and lumbar; NIOSH (from 8/22/2014 report) and NIOSH (from 10/15/2014 report); and infrared electric acupuncture & capsaicin patch 2-3 x/week for four weeks to ankles, shoulders/arms, neck, thoracic, lumbar (from 8/22/2014 report) and acupuncture & capsaicin patch 2-3 x/week for four weeks to the ankles, shoulders, knees/leg, neck, throacic, lumbar (from 10/15/2014 report), that were submitted on 11/25/2014. Utilization Review cited the MTUS, ODG, ACOEM, peer review literature, and medical practice standard of care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Cyclobenzaprine 5mg #90 from report dated 8/22/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine; muscle relaxants Page(s): 41-42; 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, fexmid) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. Limited, mixed evidence does not allow for a recommendation for chronic use. Due to quantity requested consistent with treatment duration in excess of the guidelines, the request for cyclobenzaprine is not medically necessary.

Cyclobenzaprine 5mg #30 from report dated 10/15/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine muscle relaxants Page(s): 41-42; 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, fexmid) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. Limited, mixed evidence does not allow for a recommendation for chronic use. Due to quantity requested consistent with treatment duration in excess of the guidelines, the request for cyclobenzaprine is not medically necessary.

Retrospective Omeprazole 20mg #30 from report dated 8/22/14: 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), Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 68.

Decision rationale: Per the MTUS, co-therapy with a nonsteroidal anti-inflammatory medication (NSAID) and a proton pump inhibitor (PPI) is not indicated in patients other than those at intermediate or high risk for gastrointestinal events (including age > 65 years, history of peptic ulcer, gastrointestinal (GI) bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant, or high dose/multiple NSAIDS such as NSAID plus low dose aspirin). Long term proton pump inhibitor (PPI) use (> 1 year) has been shown to increase the risk of hip fracture. There is no documentation that the injured worker has been prescribed an NSAID. None of the risk factors described above were documented. There was no documentation of any GI signs or symptoms, and no abdominal examination was documented. Due to lack of indication, the request for omeprazole is not medically necessary.

Omeprazole 20mg #30 from report dated 10/15/14: 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), Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 68.

Decision rationale: Per the MTUS, co-therapy with a nonsteroidal anti-inflammatory medication (NSAID) and a proton pump inhibitor (PPI) is not indicated in patients other than those at intermediate or high risk for gastrointestinal events (including age > 65 years, history of peptic ulcer, gastrointestinal (GI) bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant, or high dose/multiple NSAIDS such as NSAID plus low dose aspirin). Long term proton pump inhibitor (PPI) use (> 1 year) has been shown to increase the risk of hip fracture. There is no documentation that the injured worker has been prescribed an NSAID. None of the risk factors described above were documented. There was no documentation of any GI signs or symptoms, and no abdominal examination was documented. Due to lack of indication, the request for omeprazole is not medically necessary.

Retrospective Prescribed creams per report dated 8/22/14 (no other information provided):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

Decision rationale: Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended. The documentation submitted did not indicate that the injured worker had failed a trial of oral antidepressant or antiepileptic medication. The MTUS citation provides direction for the use of topical analgesics, but the identity of the drugs in question is required to determine if the prescription meets the MTUS criteria. The treating physician has not discussed the ingredients of this topical agent and the specific indications for this injured worker. Medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. A treatment plan with enough information to assess medical necessity was not provided. The prescribed cream is not medically necessary on this basis alone. Due to lack of the name of the medication, its ingredients, indications, and quantity, the request for the prescribed cream is not medically necessary.

Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2% in cream base 210 grams from report dated 10/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

Decision rationale: Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation submitted did not indicate that the injured worker had failed a trial of oral antidepressant or antiepileptic medication. The site of application and directions for use were not specified. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended. Flurbiprofen is a nonsteroidal anti-inflammatory medication (NSAID). Topical NSAIDs are indicated for osteoarthritis and tendinitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. Topical nonsteroidals are not recommended for neuropathic pain. Baclofen is not recommended in topical form. Voltaren gel is the only FDA approved topical NSAID. As Flurbiprofen is not FDA approved for use, and as baclofen is not recommended in topical form, the compound containing these medications is not recommended. Due to lack of recommendation of two of the ingredient medications, and lack of documentation of failure of oral antidepressant or antiepileptic medication, the request for Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2% in cream base 210 grams is not medically necessary.

Retrospective NIOSH from report dated 8/22/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The National Institute for Occupational Safety and Health and Official Disability Guidelines (ODG), Fitness for Duty Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 15 Stress Related Conditions Page(s): 8-9; 403, Chronic Pain Treatment Guidelines.

Decision rationale: The National Institute for Occupational Safety and Health (NIOSH) is the U.S. federal agency that conducts research and makes recommendations to prevent worker injury and illness. The ACOEM chapter on prevention outlines lifting recommendations that are based on the NIOSH 'Applications Manual for the Revised NIOSH Lifting Equation.' It describes strategies for safe lifting, including planning to avoid slippery or cluttered areas, lifting close to the body between the knee (preferably waist) and shoulder height, without bending or twisting the back, with the chin tucked in if lifting over head, with well-designed secured handles if handles are used, and weight, frequency, and speed of lifting limitations. The ACOEM chapter on stress also describes organizational stress assessment tools such as the Generic Job Stress Questionnaire developed by NIOSH. The prescription for NIOSH was included in a checklist in the request for authorization of the treatment plan, as a checkbox labeled NIOSH. No details of the reason for the request or the specific service related to NIOSH were documented. Due to lack of adequate information regarding the requested item, including a description of the services requested and the indication, the request for NIOSH is not medically necessary.

NIOSH from report dated 10/15/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The National Institute for Occupational Safety and Health and Official Disability Guidelines (ODG), Fitness for Duty Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions, Chapter 1 Prevention Page(s): 8-9, 403.

Decision rationale: The National Institute for Occupational Safety and Health (NIOSH) is the U.S. federal agency that conducts research and makes recommendations to prevent worker injury and illness. The ACOEM chapter on prevention outlines lifting recommendations that are based on the NIOSH 'Applications Manual for the Revised NIOSH Lifting Equation.' It describes strategies for safe lifting, including planning to avoid slippery or cluttered areas, lifting close to the body between the knee (preferably waist) and shoulder height, without bending or twisting the back, with the chin tucked in if lifting over head, with well-designed secured handles if handles are used, and weight, frequency, and speed of lifting limitations. The ACOEM chapter on stress also describes organizational stress assessment tools such as the Generic Job Stress Questionnaire developed by NIOSH. The prescription for NIOSH was included in a checklist in the request for authorization of the treatment plan, as a checkbox labeled NIOSH. No details of the reason for the request or the specific service related to NIOSH were documented. Due to lack of adequate information regarding the requested item, including a description of the services requested and the indication, the request for NIOSH is not medically necessary.

Urinalysis performed on 10/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines drug testing and opioids Page(s): 43, 77-78, 89, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: urine drug testing and Other Medical Treatment Guidelines UpToDate: Wald, Ron: Urinalysis in the diagnosis of kidney disease. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: The urinalysis is used in evaluating acute and chronic kidney disease, and can be used to monitor the course of kidney diseases in some patients. It may be used in patients with suspected kidney disease or kidney stones. In this case, there was no documentation of presence of suspicion of kidney disease. It is possible that the request for urinalysis represents a request for urine drug screening. The request for authorization for the treatment plan of 10/15/14 has a box checked next to the statement 'urinalysis performed on 10/14/14: UA Test determined to be medically necessary by physician for both prescribed medication management purposes as well as the monitoring of the patient to ensure that there is no illicit drug use.' Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. There was no documentation of the indication for

performance of a urinalysis. No opioid medication was documented as prescribed, and there was no discussion of a treatment plan for use of opioid medication. As the injured worker has not been prescribed opioid medication, and as there is no documentation of presence or suspicion of kidney disease, the request for urinalysis is not medically necessary.

Retrospective Infrared electric acupuncture 2-3 times a wk for 4 wks to the ankles, shoulders/arms, neck, thoracic and lumbar from report dated 8/22/14: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter: infrared.

Decision rationale: Per the MTUS, acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The MTUS recommends an initial trial of 3-6 visits of acupuncture. Frequency of treatment of 1-3 times per week with an optimum duration of 1-2 months is specified by the MTUS. Acupuncture with electrical stimulation is the use of electrical current on the needles at the acupuncture site, used to increase the effectiveness of the needles by continuous stimulation of the acupoint. The MTUS recommendations for quantity and outcomes of acupuncture are the same, whether it is provided with or without electricity. The treating physician is recommending infrared therapy as part of acupuncture treatment. The MTUS does not provide direction for infrared therapy. The ODG state that this therapy is not recommended over any other heat therapy, and that when indicated, is for treating acute low back pain along with an evidence-based exercise program. The records submitted did not include any discussion or reports of prior acupuncture, although the Utilization Review determination mentions prior acupuncture. If this is considered as an initial request for acupuncture, the number of sessions requested (2-3 times per week for 4 weeks, which would be 8-12 sessions) is in excess of the initial course recommended by the MTUS. After the initial course, the MTUS specifies that medical necessity for any further acupuncture is considered in light of functional improvement. Acupuncture treatments may be extended if functional improvement is documented. There was no documentation of functional improvement as a result of any of the prior treatments the injured worker received. Due to the quantity of sessions requested in excess of that recommended by the MTUS if the acupuncture request is considered an initial course, the lack of demonstration of functional improvement if the acupuncture request is considered as additional treatment, the request for Infrared electric acupuncture, 2-3 times a wk for 4 wks to the ankles, shoulders/arms, neck, thoracic and lumbar from report dated 8/22/14 is not medically necessary.

Infrared electric acupuncture 2-3 times a wk for 4 wks to the ankles, shoulders/arms, neck, thoracic and lumbar from report dated 10/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter: infrared.

Decision rationale: Per the MTUS, acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The MTUS recommends an initial trial of 3-6 visits of acupuncture. Frequency of treatment of 1-3 times per week with an optimum duration of 1-2 months is specified by the MTUS. Acupuncture with electrical stimulation is the use of electrical current on the needles at the acupuncture site, used to increase the effectiveness of the needles by continuous stimulation of the acupoint. The MTUS recommendations for quantity and outcomes of acupuncture are the same, whether it is provided with or without electricity. The treating physician is recommending infrared therapy as part of acupuncture treatment. The MTUS does not provide direction for infrared therapy. The ODG state that this therapy is not recommended over any other heat therapy, and that when indicated, is for treating acute low back pain along with an evidence-based exercise program. Capsaicin is recommended as an option in patients who have not responded or are intolerant to other treatments. The treating physician did not discuss the failure of other, adequate trials of conventional treatments. The records submitted did not include any discussion or reports of prior acupuncture, although the Utilization Review determination mentions prior acupuncture. If this is considered as an initial request for acupuncture, the number of sessions requested (2-3 times per week for 4 weeks, which would be 8-12 sessions) is in excess of the initial course recommended by the MTUS. After the initial course, the MTUS specifies that medical necessity for any further acupuncture is considered in light of functional improvement. Acupuncture treatments may be extended if functional improvement is documented. There was no documentation of functional improvement as a result of any of the prior treatments the injured worker received. Due to the quantity of sessions requested in excess of that recommended by the MTUS if the acupuncture request is considered an initial course, the lack of demonstration of functional improvement if the acupuncture request is considered as additional treatment, and the lack of demonstration of failure of adequate trials of conservative treatment before trial of capsaicin, the request for Infrared electric acupuncture and capsaicin patch, 2-3 times a wk for 4 wks to the ankles, shoulders/arms, neck, thoracic and lumbar from report dated 10/15/14 is not medically necessary.

Shockwave therapy 1-2 times per week for 4 weeks to the ankles, shoulders, knees/legs, neck, thoracic and lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Peer reviewed literature "Extracorporeal Shock Wave Therapy for Orthopedic Conditions".

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), knee chapter: extracorporeal shock wave therapy; low back chapter: shock wave therapy; shoulder chapter: extracorporeal shock wave therapy; ankle and foot chapter: shock wave therapy.

Decision rationale: Per the ODG, shock wave therapy for the low back is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for

treating low back pain. Regarding the knee, shock wave therapy is under study for patellar tendinopathy and for long-bone hypertrophic nonunions. New data suggests that extracorporeal shockwave therapy is ineffective for treating patellar tendinopathy, compared to the current standard of care emphasizing multimodal physical therapy focused on muscle retraining, joint mobilization, and patellar taping. Based on this information, shockwave therapy to the knee would be considered experimental and therefore not medically necessary. Shock wave therapy is recommended for calcifying tendinitis but not for other shoulder disorders. There is no evidence of benefit in non-calcific tendonitis of the rotator cuff, or other shoulder disorders, including frozen shoulder or breaking up adhesions. Regarding the foot and ankle, extracorporeal shock wave therapy (ESWT) is not recommended using high energy, but is recommended using low energy as an option for chronic plantar fasciitis. The injured worker did not have a diagnosis of chronic plantar fasciitis. Due to the lack of recommendation of shock wave therapy for multiple body parts requested, the request for Shockwave therapy 1-2 times per week for four weeks to ankles, shoulders, knees/leg, neck, thoracic and lumbar is not medically necessary.

Retrospective EMG with somatosensory bilateral upper extremities from report dated 8/22/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), EMG.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-179 and 182; 268-269, 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter: EMGneck chapter: evoked potential studies.

Decision rationale: The ACOEM recommends EMG (electromyogram) to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. The ODG notes that EMG is moderately sensitive in relation to cervical radiculopathy. The ACOEM states that sensory-evoked potentials may be used in the assessment if spinal stenosis or spinal cord myelopathy is suspected. The ODG states that somatosensory evoked potentials are recommended as a diagnostic option for unexplained myelopathy and/or in unconscious spinal cord injury patients. Somatosensory evoked potential studies are not recommended for radiculopathies and peripheral nerve lesions where standard nerve conduction velocity studies are diagnostic. The MRI of the cervical spine on 12/31/13 showed disc protrusions at multiple levels, with degenerative changes and stenosis and some contact/deviation of the exiting nerve roots, which were described as intact. None of the progress notes contain examination findings of dermatomal sensory loss/decreased strength/loss of reflexes. There is no documentation of plan for surgery or epidural steroid injection. There was no documentation of myelopathy. Due to lack of indication in accordance with the guidelines, the request for EMG with somatosensory bilateral upper extremities from report dated 8/22/14 is not medically necessary.

EMG bilateral lower extremities per report dated 10/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter: EMGs (electromyography).

Decision rationale: The ACOEM states that electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The ODG states that EMG may be useful to obtain unequivocal evidence of radiculopathy after one month of conservative therapy, but that EMGs are not necessary if radiculopathy is already clinically obvious. The MRI of the lumbar spine on 10/22/13 showed disc protrusions at L3-4, L4-5 and L5-S1 with unremarkable exiting nerve roots. None of the progress notes contain examination findings of dermatomal sensory loss/decreased strength/loss of reflexes. Due to lack of physical findings of focal neurologic dysfunction, the request for EMG bilateral lower extremities per report dated 10/15/14 is not medically necessary.

Retrospective Internal medicine consult for headaches per report dated 8/22/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM page 127 and Official Disability Guidelines (ODG), Low Back Chapter.

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: office visits.

Decision rationale: The ODG notes that office visits are recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The documentation notes that the internal medicine consultation was requested due to headaches and hypertension. Blood pressure at the visits submitted was measured at 134/89 and 123/83. Headache was listed as the reason for the internal medicine consult request but was not further discussed. There is no account of the specific symptoms, pattern of headaches, and response to any treatment. No history or examination findings related to headache and hypertension were documented. The specialty of the primary treating physician is noted on the PR2 as general practice. There is no documentation of intent for treatment that is outside of the scope of routine treatment provided by the primary treating physician. Due to lack of adequate indication, the request for internal medicine consult is not medically necessary.