

<b>Case Number:</b>	CM14-0219265		
<b>Date Assigned:</b>	02/13/2015	<b>Date of Injury:</b>	05/27/2014
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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: Texas, New York, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The applicant is a represented 29-year-old [REDACTED] employee who has filed a claim for neck pain reportedly associated with an industrial injury of May 27, 2014. In a Utilization Review Report dated December 1, 2014, the claims administrator failed to approve requests for electrodiagnostic testing of the bilateral upper extremities, a SolarCare heating system, a cold pack, and gabapentin. The claims administrator referenced a progress note of November 19, 2014 and associated RFA form of November 21, 2014 in its determination. Non-MTUS ODG Guidelines were invoked in favor of MTUS references. The applicants attorney subsequently appealed. In separate RFA forms dated November 21, 2014, electrodiagnostic testing of the bilateral upper extremities, a SolarCare heating system, and gabapentin were endorsed. In an associated progress note of November 19, 2014, difficult to follow, not entirely legible, the applicant was placed off of work, on total temporary disability, for six weeks. The applicant's primary presenting complaint appeared to be headaches. The applicant was using Neurontin. The applicant had apparently sustained a scalp laceration. No clear rationale or discussion of the articles requested was furnished, although the attending provider did seemingly state that he was furnishing the applicant with a heating-cooling system and cold pack.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV bilateral upper extremities: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

**Decision rationale:** No, the request for electrodiagnostic testing of the bilateral upper extremities was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 11, Table 11-7, page 272, the routine usage of NCV or EMG testing in the diagnostic evaluation of nerve entrapment or screening of applicants without symptoms is deemed "not recommended." Here, little-to-no rationale accompanied the November 21, 2014 Request for Authorization (RFA) form. The associated November 19, 2014 progress note made no mention of the applicant's having symptoms of upper extremity paresthesias. The applicant's primary presenting complaint appeared to be headaches. It was not clearly stated or clearly established why electrodiagnostic testing of the upper extremities was being ordered to further work up as an operating diagnosis of headaches. Therefore, the request was not medically necessary.

**Neurontin 300 mg #90: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gabarone™, generic available) Page(s): 19.

**Decision rationale:** Similarly, the request for Neurontin (gabapentin), an anticonvulsant adjuvant medication, was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 19 of the MTUS Chronic Pain Medical Treatment Guidelines, applicants using gabapentin should be asked "at each visit" as to whether there have been improvements in pain and/or function effected as a result of the same. Here, however, the applicant was off of work, on total temporary disability, it was acknowledged on November 19, 2014. The attending provider's handwritten documentation was sparse, thinly developed, not entirely legible, and did not set forth any clear or compelling evidence of improvements in pain and/or function effected as a result of ongoing Neurontin (gabapentin) usage (if any). Therefore, the request was not medically necessary.

**DME: Solar care FIR heating system (cervical spine): 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

**Decision rationale:** Similarly, the SolarCare FIR heating system was likewise not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 181 does note that at-home local applications of heat and cold are "optional" in the management of neck and upper back symptoms, as were present here on or around the date in question, by implication, ACOEM does not support more elaborate devices for delivering heat therapy and/or cryotherapy. The attending provider's documentation was, as noted previously, sparse, thinly developed, not entirely legible, did not set forth a clear or convincing case for the request at hand in the face of the unfavorable ACOEM position on the same. Therefore, the request was not medically necessary.

**DME: Cold pack (cervical spine):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

**Decision rationale:** Finally, the request for a cold pack was medically necessary, medically appropriate, and indicated here. As noted in the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 181, at-home local applications of heat and cold are deemed "optional" as methods of symptom control for neck and upper back pain complaints, as were seemingly present here on or around the date in question. The request in question appears to represent a simple, low-tech device for delivering cryotherapy. Therefore, the request was medically necessary.