

<b>Case Number:</b>	CM15-0131415		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	08/04/2014
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	06/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2015

### 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 44-year-old who has filed a claim for chronic low back pain (LBP) reportedly associated with an industrial injury of August 4, 2014. In a Utilization Review report dated June 18, 2015, the claims administrator failed to approve requests for Omeprazole and electro diagnostic testing of the bilateral lower extremities. The claims administrator referenced an RFA form dated June 11, 2015 and an associated progress note of the same date in its determination. The applicant's attorney subsequently appealed. On an RFA form dated June 11, 2015, electro diagnostic testing of bilateral lower extremities was sought. The applicant was given diagnosis of lumbar radiculopathy, chronic pain syndrome, sacroiliac ligament sprain, and adjustment disorder with depression. In an associated progress note of the same date, June 11, 2015, the applicant reported ongoing complaints of low back pain radiating into the bilateral lower extremities. The applicant was on Lexapro, naproxen, and LidoPro. The applicant was working on a part-time basis at a rate of 20 hours a week with restrictions in place, the treating provider reported. Intact sensorium was appreciated about the lower extremities. The applicant was reportedly unable to walk on his toes and heels secondary to pain. The applicant exhibited a visibly antalgic gait. An orthopedic spine surgery consultation was sought while multiple medications, including naproxen and Prilosec were renewed. The applicant was asked to continue cognitive behavioral therapy. The progress note did not contain much discussion of the need for electro diagnostic testing here. The attending provider did note that earlier lumbar MRI imaging of October 8, 2014 was notable for a disk bulge at L4-L5 with impingement of the L4-L5 and possibly the left L5 level. The applicant's past medical history was not detailed.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Bilateral lower extremity EMG/NCV: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308 - 310.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 309; 377.

**Decision rationale:** No, the request for electro diagnostic testing of the bilateral lower extremities was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309, EMG testing is "not recommended" for applicants who carry a diagnosis of clinically obvious radiculopathy. Here, the attending provider's progress note of June 11, 2015 did suggest that the applicant carry a diagnosis of clinically obvious, radiographically confirmed lumbar radiculopathy. The applicant reported ongoing complaints of low back pain radiating into the bilateral lower extremities. The attending provider posited that earlier lumbar MRI imaging of October 8, 2015 was notable for disk degeneration and disk bulging at L4-L5 with impingement at the L4 and L5 levels. The applicant had been asked to consult an orthopedic spine surgeon on the strength of said clinical symptomatology and lumbar spine MRI imaging. It was not clear, in short, why EMG testing was sought when the diagnosis of lumbar radiculopathy was seemingly clinically evident and radiographically confirmed. The EMG component of the request, thus, was not indicated. Similarly, the MTUS Guideline in ACOEM Chapter 14, Table 14-6, page 377 notes that electrical studies (AKA nerve conduction studies) are "not recommended" without clinical evidence of tarsal tunnel syndrome or other entrapment neuropathies. Here, the June 11, 2015 progress note stated that lumbar radiculopathy was seemingly the sole item on the differential diagnosis list. There was no mention of the applicant's carrying a diagnosis or suspected diagnosis of tarsal tunnel syndrome, entrapment neuropathy, generalized peripheral neuropathy, diabetic neuropathy, etc., on the June 11, 2015 progress note at issue. Since both the EMG and NCV components of the request were not indicated, the entire request was not indicated. Therefore, the request was not medically necessary.

### **Omeprazole Cap 20 mg, sixty count: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 - 69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

**Decision rationale:** Conversely, the request for Omeprazole, a proton pump inhibitor was medically necessary, medically appropriate, and indicated here. The attending provider's progress note June 11, 2015 did suggest that the applicant had developed issues with "NSAID-

induced gastritis" as of that date. Page 69 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that proton pump inhibitors such as Omeprazole are indicated in the treatment of NSAID-induced dyspepsia, as was/is seemingly present here. Introduction of Omeprazole was, thus, indicated to combat the same. Therefore, the request was medically necessary.