

Case Number:	CM15-0163052		
Date Assigned:	08/31/2015	Date of Injury:	10/29/2014
Decision Date:	10/21/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	08/19/2015

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: New York, California
 Certification(s)/Specialty: Emergency 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 53 year old female injured worker suffered an industrial injury on 10-29-2014. The diagnoses included bilateral lumbar radiculopathy, left cervical radiculopathy and lumbosacral facet arthropathy. The treatment included medications and physical therapy. The diagnostics included lumbar magnetic resonance imaging and x-rays of the cervical and lumbar spine. On 8-6-2015 the treating provider reported constant central neck pain radiating to the upper back with constant pain radiating into the left elbow and occasional pain and numbness radiating down the left arm into the hand and wrist. The pain was rated 7 out of 10 with medications and 9 to 10 without medications. She reported low back pain with intermittent pain extending to the hips and thighs to the knees and feet. The pain was rated 7 out of 10 with medications and 9 out of 10 without medications. On exam there was no tenderness to the cervical spine but had some decreased sensations and reduced range of motion. The lumbar spine had no tenderness with decreased sensations and reduced range of motion along with positive right straight leg raise. The injured worker had returned to work. The requested treatments included EMG of the bilateral lower extremities, EMG/NCS of the bilateral upper extremities and Ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: There are no reports from the prescribing physician which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. Based on the recent clinical information, there are no specific neurologic symptoms. The treating physician did not adequately address the content of prior testing, treatment, or medical records. The provider did not have previous lumbar MRI for review. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

EMG/NCS of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: There are no reports from the prescribing physician which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. Based on the recent clinical information, there are no specific neurologic symptoms. The treating physician did not adequately address the content of prior testing, treatment, or medical records. Additionally, records support request for further evaluation of symptoms in the left arm. It is unclear why bilateral studies were requested. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

Ibuprofen 600mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, specific drug list & adverse effects.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines for non-steroidal anti-inflammatory drugs recommend use for acute conditions or for acute exacerbation of conditions for short term therapy. It is recommended at lowest dose for the shortest period in patient with moderate to severe pain. Specific recommendations include osteoarthritis, back pain, and may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis in with neuropathic pain. There also needs to be evidence of functional improvement. The documentation provided indicated the medication had been in use for at least 3 months without objective efficacy or functional improvement. There was no evidence of an acute condition or an acute exacerbation of an acute condition. Therefore Ibuprofen was not medically necessary.