

<b>Case Number:</b>	CM15-0192834		
<b>Date Assigned:</b>	10/07/2015	<b>Date of Injury:</b>	11/15/2010
<b>Decision Date:</b>	12/15/2015	<b>UR Denial Date:</b>	09/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2015

### 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: Arizona, Michigan

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 injured worker is a male individual who sustained an industrial injury on 11-15-10. He is not working as he is retired. The medical records indicate that the injured worker is being treated for musculoligamentous sprain cervical spine with left upper extremity radiculitis; disc bulges C4-5 and C5-6. He currently (9-4-15) complains of moderate neck pain; increased pain at the left shoulder blade. He has sleep difficulties due to muscle spasms. Diagnostics included MRI of the cervical spine (4-17-13) showing disc bulges; musculoligamentous sprain of the thoracic spine. Treatments to date include medications: Lyrica, tramadol, Lunesta, Lidoderm patches. The treating provider's plan of care included requests for consultation with psychiatrist regarding anxiety and depression; consultation with True Sleep regarding sleep difficulties; consultation with a dentist for grinding and tooth erosion; consultation with a neurologist regarding sensory changes left face and left upper extremity; consultation with a rheumatologist regarding prior fibromyalgia diagnosis; consultation with an internist regarding irritable bowel syndrome; electromyography-nerve conduction study of bilateral upper extremities to rule out radiculopathy; Ketoralac 60 mg with Lidocaine 1 millimeter, intramuscular for relief of back symptoms. The request for authorization was not present. On 9-14-15 Utilization Review non-certified the requests for consultation with psychiatrist; consultation with True Sleep; consultation with a dentist; consultation with a neurologist; consultation with a rheumatologist; consultation with an internist; electromyography-nerve conduction study of bilateral upper extremities; Ketoralac 60 mg with Lidocaine 1 millimeter, intramuscular.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Consultation with psychiatrist: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, page 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment, Psychological evaluations.

**Decision rationale:** Per the MTUS psychological evaluation and treatment is "recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patients pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Based on the injured workers chronic pain and delayed recovery with possible co-morbid depression and anxiety, consultation with a psychiatrist is appropriate and medically necessary.

### **Consultation with True Sleep: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain / Polysomnography.

**Decision rationale:** The MTUS did not address the use of sleep studies therefore other guidelines were consulted. Per the ODG, polysomnography is "recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders." The ODG "Criteria for Polysomnography. Polysomnograms / sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); (6) Sleep-related breathing disorder or periodic limb movement disorder is suspected; (7) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and

psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended; (8) Unattended (unsupervised) home sleep studies for adult patients are appropriate with a home sleep study device with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, airflow, and EKG or heart rate)." A review of the injured workers medical records that are available to me do not reveal documentation that supports that the injured worker meets the criteria for sleep study according the guidelines, without this information it is not possible to determine medical necessity, therefore the request for consultation with true sleep is not medically necessary.

**Consultation with a dentist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, page 127.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

**Decision rationale:** Per the MTUS, Referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. Unfortunately a review of the injured workers medical records did not reveal a clear rationale for this referral, there were no subjective or objective findings related to this referral, therefore the request is not medically necessary.

**Consultation with a neurologist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, page 127.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

**Decision rationale:** Per the MTUS, Referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. Unfortunately a review of the injured workers medical records did not reveal a clear rationale for this referral, this injured worker is already being managed with lyrica for her radiculopathy / neuropathic pain therefore the request is not medically necessary.

**Consultation with a rheumatologist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, page 127.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

**Decision rationale:** Per the MTUS, Referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. Unfortunately a review of the injured workers medical records did not reveal a clear rationale for this referral, there were no subjective or objective findings related to this referral, therefore the request is not medically necessary.

**Consultation with an internist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, page 127.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

**Decision rationale:** Per the MTUS, Referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. Unfortunately a review of the injured workers medical records did not reveal a clear rationale for this referral, there were no subjective or objective findings related to this referral, therefore the request is not medically necessary.

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

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

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic)/ Electrodiagnostic studies, Nerve conduction studies.

**Decision rationale:** Per ACOEM in the MTUS, most patients presenting with true neck and upper back problems do not need special studies until a 3-4 week period of conservative care fails to improve symptoms, most patients improve quickly once red-flag conditions are ruled out. Criteria for ordering imaging studies are emergence of a red flag , physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination,

electrodiagnostic studies, laboratory tests or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurological examination is less clear, however further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV may help identify subtle focal neurologic dysfunction in patients with neck and or arm symptoms lasting more than 3-4 weeks. Per the ODG, NCS are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. A review of the injured workers medical records reveal that radiculopathy is already clinically evident there does not appear to be any diagnostic confusion in this case; therefore the request for EMG/NCV studies bilateral upper extremities is not medically necessary.

**Ketorolac 60mg with Lidocaine 1ml, IM: Upheld**

**Claims Administrator 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 based on Non-MTUS Citation Official Disability Guidelines, Pain, Injection with anaesthetics and or steroids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** Per the MTUS, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. However there is no clear rationale for the use of Ketorolac as opposed to other first line recommended oral NSAID's in this injured worker, therefore the request for Ketorolac 60mg with Lidocaine 1ml, IM is not medically necessary.