

<b>Case Number:</b>	CM15-0194829		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	04/12/2013
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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: 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 injured worker is a 48 year old male, who sustained an industrial injury on April 12, 2013. The initial symptoms reported by the injured worker are unknown. The injured worker was currently diagnosed as status post L3-4 and L4-5 interlaminar laminotomy, status post two level anterior cervical decompression and fusion, critical stenosis of lumbosacral spine, desiccation at L1-2 and L2-3 and chronic pain with secondary manifestations. Treatment to date has included home exercise, medications and diagnostic studies. He attended physical therapy sessions with slow progress noted. On August 21, 2015, the injured worker complained of headaches, neck pain with radiation to bilateral shoulder and bilateral upper extremities with tenderness, right wrist and hand pain with radiation to the right upper extremity associated with numbness and tingling, left wrist and hand pain with radiation to the left upper extremity associated with numbness and tingling, low back pain with radiation to the bilateral lower extremities down to the bilateral feet associated with numbness, tingling and weakness of the bilateral lower extremities. Physical examination revealed weakness and sensory deficit in the lower extremities. Straight leg raise test was positive bilaterally. The treatment plan included neurology consultation, hand specialist consultation, EMG and nerve conduction velocity study of lower extremities to rule out disc pathology and disc protrusion, neurosurgeon evaluation, home exercises and medications. On September 11, 2015, utilization review denied a request for EMG-NCV of bilateral lower extremities and Tylenol #3 300mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV (Electromyography)/Nerve Conduction Velocity, bilateral lower extremities:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back/Electrodiagnostic studies.

**Decision rationale:** Guidelines support electrodiagnostic studies when there is persistent neurological dysfunction that is difficult to evaluate with other means. The Guidelines generally do not support the need for nerve conduction studies on the basis of a radiculopathy, but this individual has wide spread extremity complaints and the requesting physician clearly documents the need to rule out a peripheral neuropathy, which appears reasonable. Under these circumstances, the EMG/NCV (Electromyography)/Nerve Conduction Velocity, bilateral lower extremities is supported by Guidelines and is medically necessary.

**Tylenol #3 300mg #60 (1 tablet by mouth 4-6 hours 30 day supply):** 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): Opioids, criteria for use, Opioids, long-term assessment.

**Decision rationale:** MTUS Guidelines have very specific criteria for the prescribing physician to meet to justify the long-term use of opioid medications. These criteria are not met. There is no documentation regarding the amount or length of pain relief due to use of the opioid. There is no mention of functional benefits (this may be an exception given the neurologic dysfunction). Given the lack of key documentation by the prescribing physician the Tylenol #3 300mg #60 (1 tablet by mouth 4-6 hours 30 day supply) is not Guideline supported and is not medically necessary. Updated adequate documentation could influence this recommendation on a longer-term basis.