

<b>Case Number:</b>	CM15-0196974		
<b>Date Assigned:</b>	10/12/2015	<b>Date of Injury:</b>	08/25/2010
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2015

### 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

Certification(s)/Specialty: Anesthesiology

### 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 57 year old male, who sustained an industrial injury on August 25, 2010. The initial symptoms reported by the injured worker are unknown. The injured worker was diagnosed as having chronic wrist pain, status post lumbar fusion, right knee internal derangement, medial meniscal tear and status post right knee arthroscopic surgery with residuals. Treatment to date has included diagnostic studies, home exercise, chiropractic treatment with increased range of motion but no reduction of pain, right wrist injection with significant benefit, surgery and medication. Physical therapy was noted to be providing "significant reduction" of pain, increased in strength and improvement of range of motion. On September 22, 2015, the injured worker complained of mild, aching pain in his right wrist and hand. The pain is rated as a 3 on a 1-10 pain scale. He reported no numbness or tingling. He stated that certain activities which require over use of the hand exacerbate his pain. He continued with his wrist brace for support. Physical examination revealed positive Tinel's and Phalen's. The treatment plan included work restrictions, weight bearing as tolerated, continuation with hand subspecialist, consultation for left wrist pain and medications. On September 23, 2015, the injured worker complained of low back pain rated a 7-8 on a 1-10 pain scale and right knee pain rated a 6-7 on the pain scale. He currently had spasm, pain, limited motion discomfort and difficulty walking. The treatment plan included an x-ray, medication, follow-up visit, chiropractic treatment and acupuncture. A request was made for EMG bilateral lower extremities, NCS bilateral lower extremities, pain management consultation, chiropractic rehabilitative therapy two times a week for four weeks to the lumbar spine, Apap-w Codeine 300-30mg #60, Venlafaxine ER 37.5mg #60 and aluminum cane.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyography (EMG) bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

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

**Decision rationale:** There is no documentation provided necessitating EMG testing of both lower extremities. According to the ODG, Electromyography (EMG) and nerve conduction studies are an extension of the physical examination. They can be useful in adding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies, radiculopathies, and muscle disorders. According to ACOEM Guidelines, needle EMG and H-reflex tests to clarify nerve root dysfunction are recommended for the treatment of low back disorders. In this case, there is only weakness graded as 3/5 in the right lower extremity. There is no indication for EMG studies of the bilateral lower extremities. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.

**Nerve conduction study (NCS) bilateral lower extremities:** 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), Low Back (update 07/17/15) Online Version.

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

**Decision rationale:** The request for diagnostic test NCV for the bilateral lower extremities is not medically necessary. According to the California MTUS/ACOEM Guidelines, electromyography (EMG) and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with back or leg problems, or both, lasting more than 3 to 4 weeks. The ODG further states that nerve conduction studies are 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. In the management of spine trauma with radicular symptoms, EMG/NCVs often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCVs. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.

**Pain management consultation:** 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, 2004, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, Independent Medical Examinations and Consultations.

**Decision rationale:** According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity of the requested Pain Management consultation for the lumbar spine. There is no evidence of radiculopathy or peripheral nerve entrapment. There is also no documentation that diagnostic and therapeutic management has been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

**Chiropractic rehabilitative therapy 2 times a week for 4 weeks to the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** According to MTUS, Manual Therapy or Chiropractic therapy is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the treatment of low back pain, a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, the patient has not undergone previous chiropractic treatment. The guidelines recommend a trial of up to 6 visits. The requested number of chiropractic sessions (2/week x 4 weeks to the lumbar spine) exceeds the guideline recommendations. Medical necessity for the requested chiropractic sessions has not been established. The requested sessions are not medically necessary.

**#60 Apap/w Codeine 300/30mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to the California MTUS Guidelines, APAP with Codeine (Tylenol with Codeine or Tylenol #3) is a short-acting opioid analgesic, and is in a class of drugs that has a primary indication to relieve symptoms related to pain. It is recommended as an option for mild to moderate pain. Codeine is a schedule C-II controlled substance, but codeine with acetaminophen is a C-III controlled substance. It is similar to morphine. Sixty (60) mg of codeine is similar in potency to 600 mg of acetaminophen. It is widely used as a cough suppressant. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation that this patient has failed a trial of first-line analgesic agents to support the use of codeine. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

**#60 Venlafaxine ER 37.5mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

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

**Decision rationale:** According to the ODG, Venlafaxine (Effexor) is recommended as an option in first-line treatment of neuropathic pain. Venlafaxine is a member of the selective serotonin and norepinephrine reuptake inhibitors (SNRIs) class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. It is off-label recommended for the treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. It may have an advantage over tricyclic antidepressants due to lack of anticholinergic side effects. In this case, there is no documentation the patient has neuropathic pain and there is no documentation of objective functional benefit with prior medication use. Medical necessity for the requested medication has not been established. Of note, withdrawal effects can be severe. Abrupt discontinuation should be avoided and tapering is recommended before discontinuation. The requested medication is not medically necessary.

**Aluminum cane: 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) Knee & Leg (updated 07/07/15) Online Version.

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

**Decision rationale:** According to the ODG, assistive devices for ambulation can reduce pain associated with osteoarthritis. Frames or wheeled walkers are preferable for patients with bilateral disease. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Non-use is associated with less need, negative outcome, and negative evaluation of the walking aid. In this case, the patient has a cane and has used it previously. There is no specific indication for an aluminum cane. Medical necessity for the requested item has not been established. The requested item is not medically necessary.