

<b>Case Number:</b>	CM15-0044700		
<b>Date Assigned:</b>	03/17/2015	<b>Date of Injury:</b>	03/03/2012
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2015

### 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: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 57 year old man sustained an industrial injury on 3/3/2012 when he was rear-ended his parked vehicle. He was immediately taken to the hospital and received x-rays that showed no fractures. Evaluations have also included a lumbar spine MRI. Current diagnoses include chronic low back pain, lumbar discogenic pain, and unable to rule out right L4 radiculitis/radiculopathy. Treatment has included oral medications, home H-wave unit, and physical therapy. Physician notes dated 2/16/2015 show complaints of low back pain, rated 7/10 without medications and 2/10 with medications, and intermittent numbness to his big toe. Recommendations include electrodiagnostic studies of the bilateral lower extremities, Naproxen, and Omeprazole.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyograph (EMG) Nerve conduction velocity (NCV) of bilateral lower extremities:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back-Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back Problems Section: Electrodiagnostic Studies.

**Decision rationale:** The Official Disability Guidelines comment on the use of EMG and NCV studies in the evaluation of low back problems. Nerve conduction studies (NCS) are not recommended for low back conditions; however, EMGs are recommended as an option for low back. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards: (1) EDX testing should be medically indicated (i.e., to rule out radiculopathy, lumbar plexopathy, peripheral neuropathy). (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for “screening purposes” rather than diagnosis are not acceptable. (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis. (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. (5) EMGs (Electromyography-needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. If both tests are done, the reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. (7) If both tests are done, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009) Note: For low back NCS are not recommended and EMGs are recommended in some cases, so generally they would not both be covered in a report for a low back condition. In this case, while there is justification for EMGs, there is insufficient justification to support performance of nerve conduction studies of the lower extremities. Therefore, based on the above-cited guidelines the combination of EMG and NCV of the bilateral lower extremities, is not considered as medically necessary.

**Naproxen 550mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of NSAIDs as a treatment modality. The specific recommendations for NSAIDs are as follows: Osteoarthritis (including knee and hip): 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 naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain, this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. In this case, the records suggest that the patient is using the NSAID, Naproxen, as a long-term strategy for his chronic back pain. As indicated in the above cited guidelines, NSAIDs such as Naproxen are recommended as an option for short-term symptomatic relief. Therefore, Naproxen 550 mg #60 is not considered as medically necessary.

**Omaprazole 20mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of proton pump inhibitors (PPIs) such as omeprazole. In general, PPIs are used to mitigate the potential adverse side effects of NSAIDs; in particular the risk of an adverse GI event. The specific recommendations are as follows: Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple

NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk, the suggestion is naproxyn plus low-dose aspirin plus a PPI. In this case, there is insufficient evidence that the patient has any of the risk factors described in the above cited guidelines that places him at intermediate or high-risk for a significant GI event. The patient is under 65 years of age and there is no history of an ulcer or a history of GI bleeding. For these reasons, the use of Omeprazole is not considered as medically necessary.