

<b>Case Number:</b>	CM15-0051913		
<b>Date Assigned:</b>	03/25/2015	<b>Date of Injury:</b>	01/04/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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: Florida  
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:

The injured worker is a 40 year old male, who sustained an industrial injury on 1/4/2014. The mechanism of injury was not provided for review. The injured worker was diagnosed as having headache, cervical sprain/strain, cervical radiculopathy, lumbar sprain/strain, lumbar radiculopathy, wrist sprain/strain, insomnia, anxiety and depression. Recent magnetic resonance imaging of the cervical spine was unremarkable and magnetic resonance imaging of the lumbar spine showed lumbar disc desiccation, disc protrusion and a possible ovarian cyst. Treatment to date has included physical therapy and medication management. Currently, the injured worker complains of low back pain, right wrist pain, neck and head pain and anxiety/depression. The treating physician is requesting electromyography (EMG), nerve conduction study and TENS (transcutaneous electrical nerve stimulation) trial for 30 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NCS lower extremities (DOS 1/21/2015):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Procedure Summary, EMG's.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Summary of Recommendations for Evaluating and Managing Low Back Complaints Page(s): 308-310.

**Decision rationale:** Independent medical review has been requested to determine the medical necessity of an EMG/NCS for the lower extremities that was performed on 1/21/2015. It is noted in the documentation that this patient had a normal MRI of the back prior to this date. The report was not made available for review in the provided records. MTUS recommends evaluation with EMG/NCS when there are substantial and persistent neurologic deficits. There is however limited documentation of neurologic deficits regarding the lumbar spine prior to 1/21/2015. Without additional documentation, this request is not considered medically necessary.

**TENS trial x 30 days:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-117.

**Decision rationale:** California MTUS guidelines recommend the following regarding criteria for TENS unit use: 1. Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. 2. There is evidence that other appropriate pain modalities have been tried (including medication) and failed a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. 3. Other ongoing pain treatment should also be documented during the trial period including medication usage. 4. A treatment plan including the specific short and long-term goals of treatment with the TENS unit should be submitted. 5. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended criteria since no treatment plan (that includes short and long term goals) was submitted. There is also no documentation that other treatment modalities have been tried and failed. Likewise, this request for a TENS unit trial rental is not medically necessary.

**EMG lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Procedure Summary, EMG's.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Summary of Recommendations for Evaluating and Managing Low Back Complaints Page(s): 308-310.

**Decision rationale:** Independent medical review has been requested to determine the medical necessity of an EMG/NCS for the lower extremities that was performed on 1/21/2015. It is noted in the documentation that this patient had a normal MRI of the back prior to this date. The report was not made available for review in the provided records. MTUS recommends evaluation with EMG/NCS when there are substantial and persistent neurologic deficits. There is however limited documentation of neurologic deficits regarding the lumbar spine prior to 1/21/2015. Without additional documentation, this request is not considered medically necessary.