

<b>Case Number:</b>	CM15-0112475		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	01/30/2010
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	05/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2015

### 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: 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 37 year old individual, who sustained an industrial injury on 1/30/10. The injured worker was diagnosed as having failed lumbar spine surgery, rule out right lumbar radiculopathy, rule out lumbar intradiscal component, right shoulder impingement and cervical myofascial pain with radicular symptomatology. Treatment to date has included lumbar surgery, physical therapy, activity restrictions, oral medications including Cyclobenzaprine, Hydrocodone, Tramadol, Naproxen and Pantoprazole. Currently, the injured worker complains of low back pain with right lower extremity symptoms rated 7/10, cervical pain with right upper extremity symptoms rated 7/10, right shoulder pain rated 7/10, chest wall pain rated 5/10 and insomnia which is helped with Ambien. The injured worker is currently totally disabled. Physical exam noted tenderness of cervical and lumbar spine with restricted range of motion, tenderness of right and left shoulder and spasms refractory to treatment. A request for authorization was submitted for (MRI) magnetic resonance imaging of lumbar spine, continued psychiatric follow up, (EMG) Electromyogram/(NCV)Nerve Condition Velocity of upper and lower bilateral extremities and topical Gabapentin 300grams with 3 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continued Psychiatric follow up:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, page 127.

**Decision rationale:** According to 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 for the requested Psychiatry consultation. There is limited evidence of any current significant psychological complaints aggravated by the current injury that causes functional limitations and deficits. There is also no documentation that diagnostic and therapeutic management have been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service has not been established.

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

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for diagnostic testing EMG/NCV for bilateral upper extremities is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm 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 this case, there is no indication of any recent neurological changes. Medical necessity of this testing has not been established. The requested testing is not medically necessary.

**EMG/NCV bilateral 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 (ODG); Low Back (updated 5/15/15 - Online Version, Nerve Conduction Studies (NCS).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**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. The ODG further states that nerve conduction studies (NCVs) 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 NCVs when a patient is already presumed to have symptoms on the basis of radiculopathy. In this case, an EMG done on 01/07/2013 revealed all normal findings in both lower extremities without evidence of radiculopathy. There were no new physical exam findings provided in the records. Medical necessity for the requested studies has not been established, as guideline criteria have not been met. The requested studies are not medically necessary.

**Topical Gabapentin 300mg (quantity unspecified) with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the requested topical analgesic is Gabapentin. Gabapentin is not FDA approved for a topical application. There is no peer-reviewed literature to support its use. In addition, there is no requested specified quantity. Medical necessity for the requested topical analgesic has not been established. The request for the topical analgesic is not medically necessary.