

Case Number:	CM15-0174098		
Date Assigned:	09/15/2015	Date of Injury:	09/20/2012
Decision Date:	10/16/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/03/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 38 year old male who sustained an industrial injury on 9-20-2012. A review of medical records indicates the injured worker is being treated for chronic pain syndrome, cervical radiculitis, myofascial pain, lumbosacral or thoracic neuritis or radiculitis unspecified, lumbar sprain strain, and thoracic outlet syndrome. Medical records dated 7-22-2015 noted constant neck and back pain with right upper extremity numbness. Physical examination noted decreased sensation to light touch C5-8 on the right. Treatment has included Norco, Soma, Valium, TENS, and acupuncture. MRI of the cervical spine dated 7-2-2015 revealed disc degeneration of C2-3, C3-4, and C4-5. The treatment request included EMG of bilateral upper and lower extremities and Flexeril.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG BUE (bilateral upper extremities) and BLE (the bilateral lower extremities): Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) EMG Electrodiagnostic testing of the Neck and Low Back Chapter EMG.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, and Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, EMG/NCV Low back section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, EMG/NCV of the bilateral upper extremities and lower extremities is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative or to differentiate radiculopathy from other neuropathies or non-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. For lower extremities: Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnoses are chronic pain syndrome; cervical radiculitis; and myofascial pain. Date of injury is September 20, 2012. Request for authorization is July 22, 2015. According to the progress note dated June 19, 2015, the injured worker's primary care physician prescribes Soma, Valium and Norco. According to a July 22, 2015 progress note, the treating provider prescribed Flexeril. The documentation indicates the injured worker is to continue medications from the primary care provider (Soma and Valium). Documentation states the injured worker (according to an AME) had a previous EMG that was erroneous because it did not correlate with the MRI and physical examination findings. The treating provider does not believe the previous EMG was erroneous. The previous EMG showed a right-sided C7 - C8 radiculopathy, which can suggest a thoracic outlet syndrome especially with the normal cervical MRI. Objectively, there is a single entry regarding decreased touch at C5 - C8. There is no neurologic examination in the medical record. There is no physical examination in the medical record. There are no lower extremity radicular findings documented in the medical record. There is no clinical indication or rationale for repeating an EMG of the bilateral upper extremities. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation with a clinical indication or rationale for repeating an EMG of the upper extremities, no clinical indication or rationale for performing EMGs of the lower extremity and no physical examination or neurologic evaluation in the medical record documentation (dated July 22, 2015), EMG/NCV of the bilateral upper extremities and lower extremities is not medically necessary.

Retrospective Cyclobenzaprine 7.5mg, #60 (DOS: 7/22/15): 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): Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Muscle relaxants.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, retrospective cyclobenzaprine 7.5 mg #60 date of service July 22, 2015 is not medically necessary. Muscle relaxants are recommended as a second line option short-term (less than two weeks) of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, the injured worker's working diagnoses are chronic pain syndrome; cervical radiculitis; and myofascial pain. Date of injury is September 20, 2012. Request for authorization is July 22, 2015. According to the progress note dated June 19, 2015, the injured worker's primary care physician prescribes Soma, Valium and Norco. According to a July 22, 2015 progress note, the treating provider prescribed Flexeril. The documentation indicates the injured worker is to continue medications from the primary care provider (Soma and Valium). Documentation states the injured worker (according to an AME) had a previous EMG that was erroneous because it did not correlate with the MRI and physical examination findings. The treating provider does not believe the previous EMG was erroneous. The previous EMG showed a right-sided C7 - C8 radiculopathy, which can suggest a thoracic outlet syndrome especially with the normal cervical MRI. Objectively, there is a single entry regarding decreased touch at C5 - C8. There is no neurologic examination in the medical record. There is no physical examination in the medical record. There are no lower extremity radicular findings documented in the medical record. As noted above, the documentation indicates the treating provider prescribed cyclobenzaprine. Concurrently, the documentation indicates the injured worker is to continue medications prescribed by the primary care provider including Soma. There is no clinical indication or rationale for both cyclobenzaprine and Soma taken concurrently. Objectively, there is no documentation of muscle spasm. Moreover, there is no physical examination in the record. Additionally, muscle relaxants (Soma) were prescribed as far back as June 19, 2015. The start date is not specified. Muscle relaxants are indicated for short-term (less than two weeks). The prescription duration is not specified in the medical record. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no clinical indication or rationale for two muscle relaxants (cyclobenzaprine and Soma) taken concurrently, no physical examination and no documentation demonstrating objective functional improvement, retrospective cyclobenzaprine 7.5 mg #60 date of service July 22, 2015 is not medically necessary.