

<b>Case Number:</b>	CM14-0105338		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	04/25/2011
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	06/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 30-year-old female who is reported to have sustained injuries to her low back as a result of a slip and fall occurring on 04/25/11. The records indicate that the injured worker was seen in a local emergency room and later underwent MRI of the cervical, thoracic and lumbar spines on 10/10/13. She has recently undergone repeat imaging studies of the cervical, thoracic, and lumbar spines on 05/31/14. These studies showed no substantive changes when compared to the prior studies performed in 2013. The injured worker was seen in follow-up on 06/23/14. At this time she was noted to have decreased lumbar range of motion, positive straight leg raise bilaterally, decreased sensation in the right L4, L5 and S1 distributions, decreased motor strength secondary to pain, deep tendon reflexes were 1+ on the left and 2+ on the right. The record contains a utilization review determination dated 06/10/14 in which requests for EMG/NCV of the left lower extremity, pain management consultation, six localized intense neural stimulation therapy sessions, Terocin patches, and MRI of the lumbar spine were denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Electromyography (EMG) of Left Lower Extremity: Upheld**

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

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

**Decision rationale:** The request for electromyography of the left lower extremity is not supported as medically necessary. The submitted clinical records suggest that the injured worker has a radiculopathy despite an unimpressive lumbar MRI. However, the sensory loss on the 06/23/14 note is in the right lower extremity. As such there would be no clinical indication to evaluate the left lower extremity and medical necessity is not established.

**Nerve Conduction Velocity (NCV) of 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) Lumbar & Thoracic (Acute & Chronic)

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

**Decision rationale:** The request for NCV of the lower extremities is not supported as medically necessary. The submitted clinical records suggest that the injured worker has a radiculopathy despite an unimpressive lumbar MRI. However, the sensory loss on the 06/23/14 note is in the right lower extremity. As such there would be no clinical indication to evaluate the left lower extremity and medical necessity is not established.

**Pain Management Consultation:** Upheld

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

**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:** The request for pain management consultation is not supported as medically necessary. The submitted clinical records do not identify the failure of conservative management or identify the pain generator. As such the referral to pain management would be premature and not medically necessary at this time.

**6 Localized Intense Neurostimulation Therapy for the Lumbar Spine:** 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): Neurostimulation. Clinical Evaluation Study (Gorenberg, 2013/2011)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, TENS

**Decision rationale:** The request is for 6 localized intense neurostimulation therapy sessions are not medically necessary. Current evidenced based treatment recommendations do not support the use neurostimulation as the efficacy of the treatment has not been established through rigorous clinical trials.

**Terocin Patches:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114.

**Decision rationale:** The request for Terocin patches is not medically necessary. The request is non-specific. Further, topical analgesics are large considered experimental and the safety and efficacy has not been established through rigorous clinical trials. As such, the medical necessity of this request is not established.

**MRI of the Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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

**Decision rationale:** The request for MRI of the lumbar spine is not medically necessary. The records indicate that the injured worker has had no substantive changes in her condition in the interval period. Her initial MRI of the lumbar spine was performed on 10/10/13. As there has been documentation of a progressive neurologic deficit a repeat study is not supported or clinically indicated.