

Case Number:	CM14-0137282		
Date Assigned:	09/05/2014	Date of Injury:	01/09/2012
Decision Date:	10/02/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/25/2014

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 Occupational Medicine and is licensed to practice in California. 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:

According to the records made available for review, this is a 49-year-old male with a 1/9/12 date of injury. At the time (6/16/14) of the request for authorization for EMG of the bilateral lower extremities, NCV of the bilateral lower extremities, 5 synvisc injections for the right knee, 1 refill of topical cream: TGHOT 180gm, and 1 refill of topical cream FlurFlex 180gm, there is documentation of subjective (low back pain, right knee pain, left knee pain, and right foot pain, reports radiation of the low back pain along the posterior lateral thigh on the right into the leg and foot) and objective (palpation elicits tenderness of the paralumbar muscles bilaterally, decreased lumbar range of motion, Kemp's test is positive bilaterally, lumbar facet test is positive bilaterally, 5-/5 strength of the left great toe extensors and foot evertors, decreased knee joint range of motion bilaterally) findings, current diagnoses (lumbar spine right-sided facet syndrome; bilateral knee internal derangement; lumbar disc bulges at L3-4, L4-5, and L5-S1, and anterolisthesis of L5-S1, per MRI of 4/18/14; and internal derangement of the right knee with distal patellar tendinosis, per MRI of 4/18/14), and treatment to date (medications and physical therapy). Regarding 5 synvisc injections for the right knee, there is no documentation of significantly symptomatic osteoarthritis that has not responded adequately to standard nonpharmacologic and pharmacologic treatments or is intolerant of these therapies; failure of conservative treatment (such as physical therapy, weight loss, non-steroidal anti-inflammatory medication, and intra-articular steroid injection); and plain x-ray or arthroscopy findings diagnostic of osteoarthritis.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the bilateral lower extremities: Overturned

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 (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. In addition, ODG does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the medical information available for review, there is documentation of diagnoses of lumbar spine right-sided facet syndrome; bilateral knee internal derangement; lumbar disc bulges at L3-4, L4-5, and L5-S1, and anterolisthesis of L5-S1, per MRI of 4/18/14; and internal derangement of the right knee with distal patellar tendinosis, per MRI of 4/18/14. In addition, there is documentation of evidence of radiculopathy after 1-month of conservative therapy. Therefore, based on guidelines and a review of the evidence, the request for EMG of the bilateral lower extremities is medically necessary.

NCV of the bilateral lower extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. In addition, ODG does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the medical information available for review, there is documentation of diagnoses of lumbar spine right-sided facet syndrome; bilateral knee internal derangement; lumbar disc bulges at L3-4, L4-5, and L5-S1, and anterolisthesis of L5-S1, per MRI of 4/18/14; and internal derangement of the right knee with

distal patellar tendinosis, per MRI of 4/18/14. In addition, there is documentation of evidence of radiculopathy after 1-month of conservative therapy. Therefore, based on guidelines and a review of the evidence, the request for NCV of the bilateral lower extremities is medically necessary.

5 synvisc injections for the right knee: 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), Knee & Leg (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) Knee, Hyaluronic acid injections

Decision rationale: MTUS does not address this issue. ODG identifies documentation of significantly symptomatic osteoarthritis that has not responded adequately to standard nonpharmacologic and pharmacologic treatments or is intolerant of these therapies; failure of conservative treatment (such as physical therapy, weight loss, non-steroidal anti-inflammatory medication, and intra-articular steroid injection); and plain x-ray or arthroscopy findings diagnostic of osteoarthritis, as criteria necessary to support the medical necessity of viscosupplementation injections. Within the medical information available for review, there is documentation of diagnoses of lumbar spine right-sided facet syndrome; bilateral knee internal derangement; lumbar disc bulges at L3-4, L4-5, and L5-S1, and anterolisthesis of L5-S1, per MRI of 4/18/14; and internal derangement of the right knee with distal patellar tendinosis, per MRI of 4/18/14. However, there is no documentation of significantly symptomatic osteoarthritis that has not responded adequately to standard nonpharmacologic and pharmacologic treatments or is intolerant of these therapies; failure of conservative treatment (such as physical therapy, weight loss, non-steroidal anti-inflammatory medication, and intra-articular steroid injection); and plain x-ray or arthroscopy findings diagnostic of osteoarthritis. Therefore, based on guidelines and a review of the evidence, the request for 5 synvisc injections for the right knee are not medically necessary.

1 refill of topical cream: TGHOT 180gm: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that

is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of lumbar spine right-sided facet syndrome; bilateral knee internal derangement; lumbar disc bulges at L3-4, L4-5, and L5-S1, and anterolisthesis of L5-S1, per MRI of 4/18/14; and internal derangement of the right knee with distal patellar tendinosis, per MRI of 4/18/14. However, TGHOT contains at least one drug (gabapentin) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for 1 refill of topical cream: TGHOT 180gm is not medically necessary.

1 refill of topical cream FlurFlex 180gm: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in a 0.0375% formulation, Baclofen and other muscle relaxants, and Gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of lumbar spine right-sided facet syndrome; bilateral knee internal derangement; lumbar disc bulges at L3-4, L4-5, and L5-S1, and anterolisthesis of L5-S1, per MRI of 4/18/14; and internal derangement of the right knee with distal patellar tendinosis, per MRI of 4/18/14. However, Flurflex contains at least one drug (muscle relaxants) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for 1 refill of topical cream FlurFlex 180 gm is not medically necessary.