

Case Number:	CM14-0023422		
Date Assigned:	05/12/2014	Date of Injury:	11/06/2012
Decision Date:	07/10/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/24/2014

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 and Pain Management, has a subspecialty in Interventional Spine 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:

The patient is a 36 year-old male who was injured on 11/6/2012. He has been diagnosed with cervical sprain secondary to disc herniation; lumbar sprain with left lower extremity radiculitis secondary to disc herniation. According to the 2/3/14 physiatry report from [REDACTED], the pateint presents with 1/10 cervical pain and 3/10 lumbar pain. He has mild improvement in the cervical spine with chiropractic care. The plan was to request 6 additional sessions of chiropractic care and for the lower back and pain and numbness down lower extremities, the request was for Electromyography (EMG) and Nerve Conduction Study (NCS), Bilateral Lower Extremity. [REDACTED] also provided cylco-keto-lido cream. The Utilization Review (UR) recommended against these on 2/11/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT TWO (2) TIMES A WEEK FOR THREE (3) WEEKS:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 30;58.

Decision rationale: On 2/3/14, the patient presents with 1/10 neck and 3/10 back pain. I have been asked to review for additional chiropractic x6 for the cervical spine. The prior report shows the patient had 2/10 neck pain and 3-4/10 low back pain. The patient was reported to be receiving chiropractic care, but with unknown frequency, duration or total visits. The next prior report is dated 10/31/13, and the neck pain was 6/10 and lower back was 7/10. The chiropractic care was initiated on 10/31/13. MTUS states there should be improvement with chiropractic care in 4-6 treatments. The frequency is listed as 1-2 x/week for the first 2 weeks, depending on the severity of the condition. The treatment may continued at 1 treatment per week for the next 6 weeks. The maximum duration is listed as 8 weeks. In this case the overall benefit appears to be decreasing neck pain from 6/10 to 1/10, but this is 12-weeks out. MTUS states : Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. The frequency of chiropractic care 2x/week for 3 weeks for the 12th week of chiropractic care will exceed the MTUS recommendations of 1 treatment every other week. The request is not in accordance with MTUS guidelines.

ELECTROMYOGRAPHY (EMG) OF BILATERAL LOWER EXTREMITIES:

Overtured

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, (ODG) Official Disability Guidelines-Treatment for Workers' Compensation (TWC) - Low Back Procedure Summary.

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

Decision rationale: The patient presents with lower back pain and numbness and tingling down the left leg. The radiating symptoms have been present over 4-weeks. MTUS/ACOEM states: "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." The request appears to be in accordance with MTUS/ACOEM guidelines.

NERVE CONDUCTION STUDY (NCS) OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, (ODG) Official Disability Guidelines-Treatment for Workers' Compensation (TWC) - Low Back Procedure Summary.

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

Decision rationale: The patient presents with minimal neck and lower back pain with radiation down the left leg. The physician suspects radiculopathy and recommended EMG and NCV of the lower extremities. MTUS/ACOEM does recommend EMG and the H-reflex portion of the NCV for suspected radiculopathy, but does not discuss the complete NCV. ODG was consulted. ODG guidelines states : There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The request as presented for this IMR is for NCS of the bilateral lower extremities. This is not in accordance with ODG guidelines.

CYCLO-KETO-LIDO CREAM: Upheld

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

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

Decision rationale: The patient presents with minimal neck and lower back pain with radiation down the left leg. I have been asked to review for cyclo-keto-lido cream. On page 111, under topical analgesics, MTUS gives a general statement about compounded products: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS specifically states ketoprofen is not FDA approved for topical applications. Any compounded topical product containing ketoprofen would not be recommended. The request is not medically necessary and appropriate.