MAXIMUS Federal Services

Case Number:	CM14-0065068		
Date Assigned:	07/11/2014	Date of Injury:	11/09/2011
Decision Date:	09/08/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/08/2014

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 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:

The applicant is a represented [redacted] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of November 9, 2011.Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; topical compounds; and transfer of care to and from various providers in various specialties.In a Utilization Review Report dated May 5, 2014, the claims administrator apparently denied a CT scan of the lumbar spine, denied electrodiagnostic testing of the bilateral lower extremities, and various topical compounded medications. The claims administrator did state that the applicant had a history of compression fracture at L1 and was also status post earlier failed thoracolumbar fusion surgery. It was suggested that the applicant was no longer working as a police officer.In a June 20, 2014 progress note, the applicant presented with 5-6/10 constant mid and low back pain radiating into the bilateral lower extremities with paresthesias about the same. The applicant had recently undergone CT scanning of the lumbar spine and electrodiagnostic testing of the bilateral lower extremities, it was stated. A 4/5 lower extremity strength and positive straight leg raise were appreciated. A CT scanning of the cervical spine of May 20, 2014 was notable for evidence of an earlier posterior fusion at T12-L2 to stabilize the severe compression deformity of L1. Multilevel facet arthropathy and moderate bilateral neuroforaminal narrowing were noted. Electrodiagnostic testing of May 30, 2014 was notable for chronic radiculopathy at L3, L4, L5, and S1 with superimposed mild sensorimotor polyneuropathy. The attending provider stated that his recommendation was to pursue and L4-L5 laminectomy and microdiskectomy, based on the new CT scan result and/or electrodiagnostic test results. A lumbar support, home health evaluation, and medical transportation were endorsed. The applicant was off of work, on total temporary disability.Various topical medications had apparently been prescribed on May 15,

2014, at which point the applicant was again placed off of work. At that point, CT scanning and electrodiagnostic testing were apparently pending.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT Scan of lumbar spine: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

Decision rationale: As noted in the MTUS-Adopted ACOEM Guidelines in Chapter 12, page 304, imaging studies should be reserved for cases in which surgery is being considered or red-flag diagnoses are being evaluated. In this case, the applicant apparently had active lumbar radicular complaints following an earlier failed spine surgery on and around the date in question. The CT scan in question was apparently earlier performed, despite the Utilization Review denial. The CT scanning was apparently positive and did lead the applicant's primary treating provider to make a decision to pursue a diskectomy procedure. Thus, the applicant's worsening radicular complaints, ultimately positive CT scan findings, and decision of the attending provider to pursue a surgical remedy based on the results of the same did make a compelling case for the study in question. Accordingly, the request was medically necessary.

EMG (Electromyography) of lower extremities: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: As noted in the MTUS-Adopted ACOEM Guidelines in Chapter 12, Table 12-8, page 309, needle EMG testing is "recommended" to clarify diagnosis of suspected nerve root dysfunction. In this case, the attending provider did apparently suspect a diagnosis of residual nerve root dysfunction following earlier failed lumbar spine surgery. The attending provider was having difficulty localizing the source of the applicant's residual complaints via imaging studies alone. Electrodiagnostic testing to localize the applicant's complaints was therefore indicated. The EMG testing in question did come back positive and did lead the attending provider to pursue a surgical remedy based, in part, on the results of the same. Therefore, the request was medically necessary.

NCV (Nerve conduction velocity) of the lower extremities: Overturned

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 Other Medical Treatment Guideline or Medical Evidence:ACOEM Practice Guidelines, Third Edition, Chronic Pain Chapter, Diagnostic Testing section.

Decision rationale: The MTUS does not address the topic of nerve conduction testing for a primary low back condition. As noted in the Third Edition ACOEM Guidelines, Chronic Pain Chapter, however, nerve conduction testing is recommended when there is some suspicion of an active neuropathic process, generalized neuropathy, or compression neuropathy involving the lower extremities. In this case, the attending provider did apparently had some questions about the source of the applicant's ongoing lower extremity complaints and did, apparently suspect a possible superimposed lower extremity peripheral neuropathy. The nerve conduction testing in question was apparently performed and did, in fact, demonstrate and active lower extremity sensorimotor polyneuropathy. Nerve conduction testing was therefore indicated, for all of the stated reasons. Therefore, the request was medically necessary.

Flurbiprofen 20% cream, 120g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesic Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47,Chronic Pain Treatment Guidelines Topical Analgesics topic Page(s): 111.

Decision rationale: As noted in the MTUS-Adopted ACOEM Guidelines in Chapter 3, page 47, oral pharmaceuticals are a first-line palliative method. In this case, there was no evidence of intolerance to and/or failure of multiple classes of first-line oral pharmaceuticals so as to justify usage of what page 111 of the MTUS Chronic Pain Medical Treatment Guidelines deems "largely experimental" topical agents such as the flurbiprofen containing compound in question. Therefore, the request was not medically necessary.

Ketoprofen 20%/Ketamine 10% cream, 120g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketamine Page(s): 56.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics topic Page(s): 111-112.

Decision rationale: As noted on page 112 of the MTUS Chronic Pain Medical Treatment Guidelines, ketoprofen, the primary ingredient in the compound in question, is deemed not recommended for topical compound formulation purposes. Since one or more ingredients in the

compound are not recommended, the entire compound is considered not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.

Gabapentin 10%/Cyclobenzaprine 10%/ Capsaicin 0.0375% cream, 120g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

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

Decision rationale: As noted on page 113 of the MTUS Chronic Pain Medical Treatment Guidelines, gabapentin, the primary ingredient in the compound in question, is not recommended for topical compound formulation purposes. Since one or more ingredients in the compound is not recommended, the entire compound is considered not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.