

Case Number:	CM14-0071391		
Date Assigned:	07/18/2014	Date of Injury:	03/04/2014
Decision Date:	10/15/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	05/16/2014

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 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 injured worker is a 36-year-old male who reported an injury due to heavy overhead lifting on 03/04/2014. On 03/05/2014, his diagnoses included muscle spasm of the back, back pain, lumbosacral sprain, cervical sprain/strain, and muscle spasm of the neck. On 04/29/2014, the treatment plan included medications for pain, an MRI scan of the cervical and lumbar spine, a TENS unit, and a home exercise program. A request for EMG/NCV of the lower extremities to rule out nerve damage and evaluate symptoms of radiculopathy was due to sensations of tingling, weakness, and pain in the lower extremities. A progress note of an unknown date noted that this worker had pain radiation in the right leg with decreased range of motion and decreased power to the right lower extremity. A note from 05/13/2014 revealed that this worker was receiving a TENS unit on that date. On 06/09/2014, an MRI of the cervical spine revealed deteriorating disc changes and otherwise negative MRI scan of the cervical spine. A lumbar MRI of the same date revealed L5-S1 space narrowing without disc desiccation, bulging, or herniation, a slight lumbar rotary scoliosis, and otherwise negative MRI of the lumbar spine. There was no rationale included in this injured worker's chart. A Request for Authorization dated 04/29/2014 was included.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, (transcutaneous electrical nerve stimulation), Page(s): 114-116.

Decision rationale: The request for TENS unit is not medically necessary. The California MTUS Guidelines recommend a TENS unit as an adjunct to a program of evidence based functional restoration for chronic neuropathic pain. Additionally, a treatment plan including the specific short term and long term goals of treatment with the TENS unit should be submitted. A 1 month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct with a program of evidence based functional restoration in neuropathic pain, phantom limb pain, CRPS II, spasticity, and multiple sclerosis. There was no specific treatment plan submitted with the documentation. It was noted that this worker had been using a TENS unit, but the clinical record failed to submit documentation of the objective functional benefit that was received and an objective decrease in pain that was a benefit of the TENS unit. Additionally, the request did not specify the body part or parts to have been treated with this unit, the frequency of use, or the types/quantities of supplies to have been used with this unit. Therefore, this request for a TENS unit is not medically necessary.

MRI cervical: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM <https://www.acoempracguides.org>, Cervical and Thoracic Spine, table 2, and the Official Disability Guidelines (ODG), Work Loss Data, Neck & Upper Back (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 182.

Decision rationale: The request for MRI cervical is not medically necessary. The California ACOEM Guidelines recommend that relying solely on imaging studies to evaluate the sources of pain and related symptoms carries a significant risk of diagnostic confusion, including false positive test results, because of the possibility of identifying a finding that was present before symptoms began, and therefore has no temporal association with the symptoms. MRIs are recommended for acute neck and upper back conditions when red flags for fracture or neurologic deficit associated with acute trauma, tumor, or infection are present. The submitted documentation did not contain any red flags or fracture, neurologic deficit, tumor, or infection. The need for cervical MRI was not clearly demonstrated in the submitted documentation. Therefore, this request for MRI cervical is not medically necessary.

Bilateral lower extremity EMG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM

<https://www.acoempracguides.org/lowback>, Table 2 and on the Official Disability Guidelines (ODG), Work Loss Data Institute, Low Back - Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 710-711.

Decision rationale: The request for Bilateral lower extremity EMG is not medically necessary. The California ACOEM Guidelines state that electrodiagnostic studies are not recommended for patients with acute, subacute, or chronic back pain who do not have significant lower extremity pain or numbness. As imaging studies, especially CT and MRI, have progressed, the need for EMG has declined. There are no quality studies regarding the use of electromyography. Additionally, the submitted documentation revealed symptomatology in the lower right extremity, and there was no documentation of bilateral involvement. Therefore, this request for Bilateral lower extremity EMG is not medically necessary.

Lidopro 121 gm with refill: 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: The request for Lidopro 121 gm with refill is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded for pain control, including local anesthetics. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Lidopro contains capsaicin 0.0325%, lidocaine 4.5%, menthol 10%, and methyl salicylate 25.5%. Capsaicin is available as a 0.025% formulation as a treatment for arthritis. There have been no studies of a 0.0375% formulation of capsaicin, and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The only form of FDA approved topical application of lidocaine is the 5% transdermal patch. The guidelines do not support the use of this compounded cream. Therefore, this request for Lidopro 121 gm with refill is not medically necessary.

Bilateral lower extremity NCV: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM <https://www.acoempracguides.org/lowback>, Table 2 and on the Official Disability Guidelines (ODG), Work Loss Data Institute, Low Back - Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 303-305.

Decision rationale: The request for Bilateral lower extremity NCV is not medically necessary. The California ACOEM Guidelines suggest that assessment of patients should include general observations, including changes in position, stance and gait, regional examination of the spine, neurological examination, testing for nerve root tension, and monitoring of pain behavior during range of motion as a clue to origin of the problem. The submitted documentation revealed symptomatology in the lower right extremity, but no lower left extremity involvement. There is no rationale for bilateral NCV. Therefore, this request for Bilateral lower extremity NCV is not medically necessary.

MRI lumbar: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM <https://www.acoempracguides.org/lowback>, Table 2 and on the Official Disability Guidelines (ODG), Work Loss Data Institute, Low Back - Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 303-305. Decision based on Non-MTUS Citation Low Back, Lumbar & Thoracic,
MRIs

Decision rationale: The request for MRI lumbar is not medically necessary. The California ACOEM Guidelines recommend that relying solely on imaging studies to evaluate the source of pain and related symptoms carries a significant risk of diagnostic confusion, including false positive test results, because of the possibility of identifying a finding that was present before symptoms began, and therefore has no temporal association with the symptoms. The Official Disability Guidelines recommend that an MRI for uncomplicated low back pain with radiculopathy is not recommended until after at least 1 month of conservative therapy. Conservative care includes a self performed exercise program as an extension of prior physical therapy that includes ongoing back strengthening and flexibility exercises, as well as aerobic exercises, and recommended appropriate drug therapies, which include trials of antidepressants and/or anticonvulsants in conjunction with analgesics. There was no evidence in the submitted documentation of failed trials of antidepressants or anticonvulsants, or previously failed physical therapy. The clinical information submitted failed to meet the evidence based guidelines for MRI. Therefore, this request for MRI lumbar is not medically necessary.