

<b>Case Number:</b>	CM15-0169420		
<b>Date Assigned:</b>	09/10/2015	<b>Date of Injury:</b>	09/24/2014
<b>Decision Date:</b>	10/28/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 53 year old male who sustained an industrial injury on September 24, 2014. The worker was employed as a laborer for a construction company. The accident was described as while working on a ladder he fell approximately 20 feet down and with resulting injury. An initial evaluation dated November 04, 2014 reported present subjective complaint of bilateral shoulders, right wrist, low back, right hip, right upper leg, right ankle pains. The following diagnoses were applied: bilateral shoulder strain and sprain rule out internal derangement; right wrist pain, rule out carpal tunnel syndrome; low back pain; lumbar spine strain and sprain rule out herniated nucleus pulposus; rule out lumbar radiculopathy; status post right femur fracture with open reduction and internal fixation; right hip strain and sprain, rule out internal derangement; right knee strain and sprain rule out internal derangement; and right ankle strain and sprain rule out internal derangement. The plan of care noted: prescribing the following medications: Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Flexeril, Ketoprofen topical compound cream. The following recommendations were made: radiographic study of bilateral shoulders, right wrist, right hip, right thigh, right knee, right ankle, and lumbar spine; undergo nerve conduction study of bilateral upper extremities; referred for functional capacity evaluation; course of physical therapy and acupuncture sessions, localized neurostimulation therapy, and utilize both transcutaneous nerve stimulator and Terocin patches. She is to remain temporarily totally disabled.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG (Elelctromyogram) lower extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, EMGs, Electrodiagnostic Studies.

**Decision rationale:** Regarding the request for EMG and nerve conduction study of the bilateral lower extremities, ACOEM Chapter 12 states that electromyography, include H-reflex tests, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. The electromyography component of electrodiagnostic testing is in fact the primary component in detecting lumbar radiculopathy. ODG further specify that EMGs are "recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Within the documentation available for review, the patient have EMG and nerve conduction study approved on 3/12/2015. However, this report is not provided and it is unclear if this study has been completed. There is no recent documentation that the patient has failed conservative treatment. Furthermore, there is no statement regarding how the patient's symptoms have changed since the most recent EMG and nerve conduction study. Given this, the current request is not medically necessary.

**NCS (nerve conduction studies) lower extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies.

**Decision rationale:** Regarding the request for NCV of the lower extremities, ACOEM Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The guidelines further specify that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Within the documentation available for review, the patient have EMG and nerve conduction study approved on 3/12/2015. However, this report is not provided and it is unclear if this study has been completed. There is no recent documentation that the patient has failed conservative treatment. Furthermore, there is no statement regarding how the patient's symptoms have changed since the most recent EMG and nerve conduction study. Given this, the current request is not medically necessary.

**Flurbi (NAP) cream LA Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5%) 180gm #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** With regard to the request for Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5% which contains a topical anti-epileptic, the Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. There is further stipulation that there is no peer-reviewed literature to support the use of topical anti-epileptics. Furthermore, the same guidelines specify that if one component of a compounded medication is not recommended, then the entire formulation is not recommended. Given these guidelines, this request is not medically necessary.

**Gabaclyotram (Gabapentin 10%/cyclobenzaprine 6%/Tramadol 10%) 180mg #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** This topical compound consists in part of topical cyclobenzaprine. Regarding the request for topical Flexeril, CA MTUS states that topical muscle relaxants are not recommended as there is no peer-reviewed literature to support the use of topical baclofen or any other muscle relaxant as a topical product. Furthermore, the same guidelines specify that if one component of a compounded medication is not recommended, then the entire formulation is not recommended. Given these guidelines, this request is not medically necessary.

**Tramadol 50mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

**Decision rationale:** Regarding the request for Ultram (tramadol), Chronic Pain Medical Treatment Guidelines state that Ultram is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional

improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function, and no documentation regarding side effects. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Ultram (tramadol) is not medically necessary.