

Case Number:	CM15-0216250		
Date Assigned:	11/06/2015	Date of Injury:	09/13/2012
Decision Date:	12/18/2015	UR Denial Date:	10/19/2015
Priority:	Standard	Application Received:	11/03/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 41 year old male who sustained a work-related injury on 9-13-12. Medical record documentation revealed the injured worker was status post total left hip revision surgery on 4-15-15. Documentation on 9-22-15 indicated the injured worker reported he was not doing well with his hip and noted that there were at times two to three days of pain. His pain was lateral and posterior and he had difficulty putting weight on his hip. The injured worker felt he may have some nerve pain related to his prior work. Objective findings included a good straight leg raise of the left hip and good hip abduction and strength. His range of motion included flexion to 120 degrees, extension to 0 degrees, internal rotation to 20 degrees and external rotation to 30 degrees. He had some tenderness to palpation of the greater trochanter and mild Trendelenburg test on the left side. Diagnoses associated with the evaluation included right hip degenerative disc disease, status post left total hip revision, and lumbosacral spine disease. X-rays revealed the left hip prosthesis to be well-fixed without loosening or wear, a good acetabular component and a well-fixed femoral component without evidence of radiolucent lines. The evaluating physician noted that the injured worker felt that he may have nerve damage and recommended electromyogram of the bilateral lower extremities. The physician recommended compound medication to treat the trochanteric bursitis of the left hip. On 10-19-15, the Utilization Review physician determined Neuro EMG Legs and ketamine compounded cream 240 grams (5 refills) was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neuro EMG (electromyography) of the legs: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgtwc/Low_Back.htm).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Summary.

Decision rationale: According to the guidelines, an EMG is recommended to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection. It is not recommended for the diagnoses of nerve root involvement if history and physical exam, and imaging are consistent. An NCV is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. In this case, the claimant had hip surgery and prior MRI findings of disc bulging. Straight leg raise was positive for back pain but did not indicate radiating pain. There were no abnormalities in sensation or strength. The symptoms are often consistent with hip replacement and disc bulging. The request for EMG is not medically necessary.

Ketamine compounded cream 240gm with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Gammaitoni, 2000 <http://www.odg-twc.com/odgtwc/pain.htm>.

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

Decision rationale: According to the guidelines, topical Ketamine has only been studied for CRPS and is under review. In this case, the claimant does not have CRPS but rather chronic hip pain. Long-term use of topicals is not recommended. The topical Ketamine with 5 refills is not medically necessary.