

Case Number:	CM15-0046359		
Date Assigned:	04/02/2015	Date of Injury:	08/18/2010
Decision Date:	05/01/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/11/2015

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 56 year old male, who sustained an industrial injury on 8/18/10. He has reported bilateral wrist and low back injury. The diagnoses have included lumbar spine discopathy, lumbar radiculopathy; Treatment to date has included medications, Epidural Steroid Injection (ESI), and Home Exercise Program (HEP). Currently, as per the physician progress note dated 1/30/15, the injured worker complains of worsening pain in the spine and left leg. He complains of aching pain in the low back and rated the pain 8/10 on pain scale and worsens with activities to 9/10. He also complains of wrist pain rated 7/10 and pain and numbness left leg rated 6/10. He states that he takes Ibuprofen as needed with benefit. Physical exam revealed abnormal toe- walk on the left and heel- walk abnormal on the left. There was tenderness in the lumbar region on the left, positive muscle spasm in the lumbar spine, decreased range of motion; spasm was noted, with decreased sensation in the foot and calf on the left. The sciatic nerve test was positive on the left and straight leg raise was positive bilaterally. The physician noted that the injured worker has tried all modalities even epidurals which only last short term. The injured worker is now considering surgery and therefore updated diagnostics will be needed. The physician requested treatment/ treatments include/ included EMG/NCV right extremity and NCV left lower extremity, IF UNIT, and Gabapentin/Cyclobenzaprine/Ketoprofen/Capsaicin/Menthol/Camphor cream 240gm. The report dated February 6, 2015 indicates that the patient has low back pain radiating into the left lower extremity. There is decreased sensation in the left foot and posterior lateral calf on the left. There is also decreased strength on the left. The treatment plan

recommends MRI of the lumbar spine and EMG/NCV study of bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV right extremity and NCV left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG/NCV of the lower extremities, Occupational Medicine 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. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, there are no subjective complaints or physical examination findings identifying specific nerve root compromise in the right lower extremity. Additionally, it appears that diagnostic studies have previously been performed on this patient, and it is unclear how the patient symptoms and findings have changed since the time of the most recent studies. In the absence of clarity regarding those issues, the currently requested EMG/NCV right extremity and NCV left lower extremity is not medically necessary.

IF UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 118-120 of 127.

Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative

treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

Gabapentin/Cyclobenzaprine/Ketoprofen/Capsaicin/Menthol/Camphor cream 240gm:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Gabapentin/Cyclobenzaprine/Ketoprofen/Capsaicin/ Menthol/Camphor cream 240gm, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants drugs are not supported by the CA MTUS for topical use. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. As such, the currently requested Gabapentin/ Cyclobenzaprine/Ketoprofen/Capsaicin/Menthol/Camphor cream 240gm is not medically necessary.