

Case Number:	CM15-0111311		
Date Assigned:	06/17/2015	Date of Injury:	01/20/2015
Decision Date:	08/18/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	06/09/2015

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: North Carolina, Georgia
 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:

The injured worker is a 48-year-old female who sustained an industrial injury on 1/20/15. The injured worker was diagnosed as having cervical spine sprain/strain, lumbar spine sprain/strain, and lumbar radiculopathy. Currently, the injured worker was with complaints of back pain. Previous treatments included physical therapy, chiropractic treatments and activity modification. Previous diagnostic studies included radiographic studies. The plan of care was for an electromyography, Lumbar-Sacral Orthosis and medication prescriptions.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral lower extremities and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: CA MTUS/ACOEM allows for the use of EMG and NCV for the evaluation of radiculopathy and peripheral neuropathy when symptoms are present for more than a few weeks. These tests may help identify subtle focal neurologic dysfunction in cases of lower extremity symptoms. The submitted records do not document any neurologic findings in the lower extremities. Therefore, there is no indication for EMG or PNCV of lower extremities. This request is not medically necessary.

Cyclo/Tramadol Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 111-113.

Decision rationale: CA MTUS recommends limited use of topical analgesics. These are primarily recommended for neuropathic pain with antidepressants and anti-epileptics have failed. CA MTUS specifically prohibits the use of combination topical analgesics in which any component of the topical preparation is not recommended. Muscle relaxants, such as Cyclobenzaprine, in topical formulation are explicitly not approved in the CA MTUS. As such, the request for cyclo/tramadol is not medically necessary and the original UR decision is upheld.

IF Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 118-120.

Decision rationale: CA MTUS does not recommend the use of an Inferential Current Stimulation (ICS) as an isolated intervention. There is limited evidence for its effectiveness when combined with other interventions such as return to work, exercise and medications. Trials have been performed on neck, shoulder, jaw, knee and low back pain. ICS may be possibly appropriate for the following conditions: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.) If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. In this case there is no documentation that there are limiting side effects of medication, that there is limited efficacy of medication, that pain does not respond to conservative measures or that there is any history of substance abuse. The claimant is actively undergoing conservative therapy (chiropractic). As such, the claimant meets none of the conditions for which coverage of ICS may be considered and ICS is not medically necessary. I am upholding the original UR decision.

LSO - Lumbar Sacral Orthosis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Lumbar support.

Decision rationale: CA MTUS addresses the use of lumbar support in the chapter on low back complaints. Lumbar support has not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG addresses use of lumbar support in the section on Low Back and states that lumbar support may be indicated in cases of compression fracture, spondylolithesis and documented instability. In this case, the injury was over a year ago, is no longer in the acute phase of management, and there is no documentation of any compression fracture, spondylolithesis or instability. Lumbar support in the form of lumbar sacral orthosis is not medically necessary.