

Case Number:	CM14-0117262		
Date Assigned:	08/06/2014	Date of Injury:	10/04/2004
Decision Date:	12/18/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/25/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine 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 59-year-old female who reported injuries of unspecified mechanism on 10/04/2004. On 04/21/2014, her diagnoses included cervical chronic sprain/strain syndrome with mild cervical discopathy, lumbar chronic sprain/strain syndrome with mild lumbar discopathy, carpal tunnel syndrome, and status post right shoulder replacement on 04/03/2012. Her complaints included right shoulder pain with pins and needles rated 5/10 with stabbing pain in the right arm rated 6/10, stabbing pain in her right hand and fingers with numbness rated 8/10, stabbing pain in the low back with numbness rated 5/10 and stabbing pain in the bilateral knees rated 7/10. It was also noted that she was morbidly obese and was taking medication for weight loss but was not having a great deal of success losing weight. Upon examination of the cervical spine, there was mild tenderness noted in the paracervical musculature. Her ranges of motion measured in degrees were flexion 40/50, extension 30/60, bilateral flexion 35/45 and bilateral rotation 35/80. She had limited ranges of motion in the right shoulder. Her lumbar ranges of motion measured in degrees were flexion 20/60, extension 10/25, right and left lateral bend was 10/25. She had full bilateral wrist and finger mobility, with mild diminution of sensibility in the upper extremities median nerves. X-rays of the cervical spine revealed a single level collapse of the disc at C3-4 with minimal anterior osteophytes at the other discs. X-rays of the lumbar spine showed a grade 1 anterolisthesis at L4-5. X-rays of the right shoulder show the hemiarthroplasty to be in good position. She was deemed to be at maximum medical improvement. The importance of home exercises and weight reduction were stressed to her. The TG hot cream was being prescribed for immediate pain relief. No rationale was provided for the other requests. There was no Request for Authorization included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for intramuscular injection of Vitamin B12 complex 2cc: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Vitamin B

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain, Vitamin B.

Decision rationale: The retrospective request for intramuscular injection of vitamin B12 complex 2cc was not medically necessary. The Official Disability Guidelines do not recommend vitamin B. Vitamin B is frequently used for treating peripheral neuropathy, but its efficacy is not clear. There are only limited data and randomized trial tests of the efficacy of vitamin B for treating peripheral neuropathy, and the evidence is insufficient to determine whether vitamin B is beneficial or harmful. In a comparison of vitamin B with placebo, there was no significant short term benefit in pain intensity. The guidelines do not support the use of vitamin B12 complex. Additionally, the body part that was injected was not included in the request. Therefore, this retrospective request for intramuscular injection of vitamin B12 complex 2cc was not medically necessary.

Electromyography (EMG) of the upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): table 8-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, electromyography (EMG) and nerve conduction studies (NCS) sections

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

Decision rationale: The request for electromyography (EMG) of the upper extremities is not medically necessary. The California ACOEM Guidelines note that electromyography is not recommended for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent. EMG is recommended to clarify nerve root dysfunction in cases of suspected disc herniation preoperatively or before epidural injection. There was no evidence in the submitted documents of suspected disc herniation, nor was there a plan for epidural injections. This injured worker had symptomatology in her right upper extremity only. There was no justification for electromyography of both upper extremities. The clinical information submitted failed to meet the evidence based guidelines for electromyography. Therefore, this request for electromyography (EMG) of the upper extremities is not medically necessary.

Nerve Conduction Velocity (NCV) of the upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): table 8-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, electromyography (EMG) and nerve conduction studies (NCS) sections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

Decision rationale: The request for nerve conduction velocity (NCV) of the upper extremities is not medically necessary. Per the California ACOEM Guidelines, nerve conduction velocity study is not recommended for all acute, sub-acute, and chronic hand, wrist, and forearm disorders. Electromyography/nerve conduction velocity studies are only recommended for a diagnosis of carpal tunnel syndrome. Routine use of NCV or EMG in diagnostic evaluation of nerve entrapment or screening in patients without corresponding symptoms is not recommended. This injured worker had symptomatology in her right upper extremity only. There was no justification for bilateral electrodiagnostic studies. Therefore, this request for nerve conduction velocity (NCV) of the upper extremities is not medically necessary.

Fluriflex cream 240gm; apply twice daily: Upheld

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

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

Decision rationale: The request for Fluriflex cream 240gm; apply twice daily is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized control 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 in combination for pain control including NSAIDs and muscle relaxants. 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. The only FDA approved NSAID for topical application is Voltaren gel 1% (diclofenac), which is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. Fluriflex cream contains Flurbiprofen 10% and Cyclobenzaprine 10%. Flurbiprofen is not FDA approved for topical application in humans. There is no evidence for the use of any muscle relaxant as a topical product. The guidelines do not support the use of this compounded cream. Additionally, the body part of parts to have been treated were not specified in the request. Therefore, this request for Fluriflex cream 240gm; apply twice daily is not medically necessary.

TGHot cream 240gm; apply twice daily: Upheld

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

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

Decision rationale: The request for TGHOT cream 240gm; apply twice daily is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized control 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 antiepileptic medications, opioids, and Capsaicin. 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. TG hot cream contains Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%, and Capsaicin 0.05%. Gabapentin is not recommended. There is no peer reviewed literature to support its use. Capsaicin is generally available as a 0.025% formulation as a treatment for osteoarthritis. There have been no studies of a 0.05% formulation of Capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The guidelines do not support the use of this compounded cream. Additionally, the body part of parts to have been treated were not included in the request. Therefore, this request for TGHOT cream 240gm; apply twice daily is not medically necessary.

AppTrim two (2) capsules twice daily #120; two (2) bottles for two (2) months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Medical Foods

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Medical food.

Decision rationale: The request for AppTrim two (2) capsules twice daily #120; two (2) bottles for two (2) months is not medically necessary. The Official Disability Guidelines defines medical foods as a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. To be considered, the product must at a minimum meet the following criteria: (1) The product must be a food for oral or tube feeding; (2) The product must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; (3) The product must be used under medical supervision. AppTrim is a medical food which is advertised to meet the nutritional requirements of obese patients and to be used for specific dietary management of obesity. There are no distinctive nutritional requirements for obesity. The guideline criteria have not been met. Therefore, this request for AppTrim two (2) capsules twice daily #120; two (2) bottles for two (2) months is not medically necessary.