

Case Number:	CM14-0092607		
Date Assigned:	07/25/2014	Date of Injury:	11/01/2013
Decision Date:	09/26/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	06/18/2014

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 Family 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:

This is a 46-year-old female with an 11/1/13 date of injury, when she injured her upper extremities due to repetitive continued trauma. The patient underwent right elbow cubital tunnel release on 12/13/11. The reviewer's report dated 5/15/14 stated that the patient underwent EMG/NCS (Electromyogram/Nerve Conduction Study) of the right upper extremity in 2011, which revealed right cubital tunnel. She also underwent EMG/NCS of the right extremity in 2012 which revealed a right carpal tunnel syndrome. The patient was seen on 5/9/14 with complaints of persistent neck pain, right shoulder pain, right elbow pain and bilateral wrist and hand pain. The patient's pain was 7/10 with Motrin and 4/10 without the medication. Exam findings of the cervical revealed limited range of motion, tenderness to palpation over the bilateral trapezius muscles, positive shoulder depression test and positive Spurling's test on the right. The sensation was 4/5 in the C5-C8 dermatomes on the right and C7-C8 on the left with 5/5 sensation on the left C5 and C6. The strength was 4/5 bilaterally. The exam of the right shoulder revealed limited range of motion and acromioclavicular joint tenderness on the right. The strength was 4/5 in flexion and abduction of the left shoulder. There was positive Tinel's sign along the ulnar nerve distribution and medical epicondyle. The examination of the wrist and hands revealed asymmetrical loss of range of motion and positive Phalen's and Tinel's signs on the right and the sensation was 4/5 in the median and ulnar nerves bilaterally. The patient was approved for NCS of bilateral upper extremities. The diagnosis is rotator cuff tear, chronic cervical strain, and bilateral carpal tunnel syndrome, left lower extremity radicular pain, bilateral upper extremity radicular pain. Treatment to date: physical therapy, cortisone injections and work restrictions. An adverse determination was received on 5/15/14. The request for Electromyogram (EMG) of the Bilateral Upper Extremities was denied due to no evidence of radiculopathy in the upper extremities. The request for Kera-Tek gel was denied due to no

evidence that the patient failed trials of antidepressants or anticonvulsants and no evidence of intolerance to oral pain medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG - TWC.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238, table 10-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (Neck and Upper Back Chapter).

Decision rationale: CA MTUS criteria for EMG of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. The physical examination performed on 5/15/14 did not reveal any significant motor loss in the upper extremities. In addition, the NCS were approved. There is no rationale with regards to the patient's need for an EMG. In addition, the patient underwent 2 EMG/NCS since the injury and the physical examination did not reveal any new symptoms. Therefore, the request for EMG of the Bilateral Upper Extremities is not medically necessary.

Kera-Tek Gel 4oz: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Page(s): 105.

Decision rationale: A search of online resources revealed that Kera-Tek gel active ingredients include menthol 16%, topical analgesic, and methyl Salicylate 28% used for temporarily relief of minor aches and pains of muscles and joints associated with single backache, arthritis, strains, bruises and sprains. CA MTUS states that topical salicylates are significantly better than placebo in chronic pain. There is no clear rationale with regards to Kera-Tek gel. The area of the application is not clear and there is a lack of documentation indicating the patient's medical management routine. Therefore, the request for Kera-Tek Gel 4oz is not medically necessary.