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| Case Number: | CM14-0121692 | | |
| Date Assigned: | 08/06/2014 | Date of Injury: | 06/27/2008 |
| Decision Date: | 01/02/2015 | UR Denial Date: | 07/03/2014 |
| Priority: | Standard | Application Received: | 08/01/2014 |

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 and Rehabilitation 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 (IW) is a 53-year-old woman who sustained an injury to her neck from a 6/27/08 industrial injury while employed with [REDACTED]. She was treated with C4-6 anterior cervical discectomy and fusion in 2009. She later underwent right shoulder arthroscopy with rotator cuff repair and biceps tendonesis. She was more recently treated with ESI to C7-T1 which provided 70% reduction in her pain level, but has since returned. She has persistent complaints of pain at the base of her neck and in the periscapular muscles according to the records. Records also indicate tenderness in the right periscapular muscles with moderate limitation in shoulder flexion. She has good shoulder strength and no evidence of laxity. The current diagnoses are: 1. Cervical disc displacement 2. Status post cervical laminectomy and fusion 3. Status post, right shoulder arthroscopy. The utilization review report dated 7/3/14 denied the request for retrospective B12 injection, date 6/3/14 and for retrospective Toradol injection, dated 6/3/14 based upon lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective B12 injection , date 6/3/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain, updated 6/10/14, 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) ODG pain chapter, Vitamin B

Decision rationale: The patient presents with persistent complaints of pain at the base of the neck and in the right periscapular region. The current request is for Retrospective B12 injection, date 6/3/14. California (MTUS) or American College of Occupational and Environmental Medicine (ACOEM) does not discuss vitamin B12 injections. Official Disability Guidelines (ODG) does not recommend Vitamin B for chronic pain conditions. Aetna clinical policy guidelines also state that Vitamin B-12 Therapy injections are medically necessary with the following diagnoses or conditions: Anemia; GI disorders; neuropathy associated with malnutrition; alcoholism; pernicious anemia or Posterolateral sclerosis; Dementia secondary to B-12 deficiency; Homocystinuria; Patient's receiving Methotrexate, Almita; Methomonicaciduria; B-12 deficiency due to metformin not corrected by oral B-12; or Retrobulbar neuritis associated with heavy smoking. With a diagnoses of status post neck and shoulder surgery and persistent neck and shoulder pain, the guidelines fail to recommend B12 for such conditions. The requested treatment is not medically necessary and appropriate.

Retrospective Toradol injection date 6/3/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory) Page(s): 67-68. Decision based on Non-MTUS Citation ODG, Pain, updated 6/10/14

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketorolac (Toradol).

Decision rationale: The patient presents with persistent complaints of pain at the base of the neck and in the right periscapular region. The current request is for Retrospective Toradol injection date 6/3/14. There is no discussion regarding why non-steroidal anti-inflammatory drugs (NSAIDs) were required and there is no discussion stating that oral NSAIDs are contraindicated for this patient. The MTUS guidelines state for Ketorolac (Toradol), "This medication is not indicated for minor or chronic painful conditions." The current documentation provided by the treating physician indicates that the patient has chronic pain and there is no documentation of a moderate to severe acute flare-up that might require a Toradol injection. The requested treatment is not medically necessary and appropriate.