MAXIMUS Federal Services

Case Number:	CM14-0193949		
Date Assigned:	12/01/2014	Date of Injury:	03/14/2000
Decision Date:	01/16/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/19/2014

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, 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:

This is a patient with a date of injury of 3/14/00. A utilization review determination dated 10/31/14 recommends non-certification of EMG/NCV, IM injections of Depo Medrol/Kenalog and vitamin B, and topical cream. Electrodiagnostic testing was performed in the past. It referenced a 10/17/14 medical report (no current reports from the provider available for review) identifying pain in the neck, right shoulder, and tingling in the right hand and fingers. Patient reports trouble sleeping, numbness, and stress. On exam, there is tenderness, limited ROM, unspecified diminished reflexes, sensation, and strength, mildly positive head compression test, positive Tinel's and Phalen's bilaterally, diminished sensation bilateral median distribution, right wrist motor power 3/5. Updated EMG/NCV is requested as the patient is having a substantial increase in numbness and tingling.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV study of the upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

Decision rationale: Regarding the request for EMG/NCV study of the upper extremities, CA MTUS states that appropriate electrodiagnostic studies (EDS) may help differentiate be- tween CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. Within the documentation available for review, the patient had prior electrodiagnostic testing, but the date and results of that testing is not identified. The results of prior testing may obviate the need for additional testing. In light of the above issues, the currently requested EMG/NCV study of the upper extremities is not medically necessary.

Retrospective intramuscular injection of 1cc of Depo Medrol and 2cc of Kenalog: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Low Back Chapters, Corticosteroids

Decision rationale: Regarding the request for IM injection of Depo Medrol and Kenalog, CA MTUS states that invasive techniques (e.g. injection of corticosteroids) have no proven benefit in treating acute neck and upper back symptoms. ODG notes that they are recommended in limited circumstances for acute radicular pain. Within the documentation available for review, there is no evidence of acute radicular pain. In light of the above issues, the currently requested IM injection of Depo Medrol and Kenalog is not medically necessary.

Retrospective intramuscular injection of 2cc of B12 complex; 2cc of B12 cyanocobalamin: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: Regarding the request for vitamin B injection, California MTUS guidelines do not address the issue. ODG states that vitamin B is not recommended. Vitamin B is frequently used for treating peripheral neuropathy but its efficacy is not clear. A recent meta-analysis concluded that there are only limited data in randomized trials testing the efficacy of vitamin B for treating peripheral neuropathy and the evidence is insufficient to determine whether vitamin B is beneficial or harmful. Within the documentation available for review, there is no documentation that this patient has a vitamin B deficiency that would support the use of supplementation, as it is not supported in the management of pain. As such, the current request for vitamin B injection is not medically necessary.

Ketoprofen/Cyclobenzaprine/Diclofenac/Lidocaine cream 10/2/5/5% 180gm cream, apply 1-2 grams to affected area: Upheld

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

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

Decision rationale: Regarding the request for ketoprofen/cyclobenzaprine/diclofenac/lidocaine cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical ketoprofen is "not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." Topical lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Muscle relaxants are not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested ketoprofen/cyclobenzaprine/diclofenac/lidocaine cream is non-certified.