

Case Number:	CM15-0034041		
Date Assigned:	02/27/2015	Date of Injury:	06/23/2014
Decision Date:	04/14/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	02/23/2015

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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 39 year old female who sustained a work related injury June 23, 2014, described as cumulative with increased sharp pain in the neck and left shoulder. She was initially treated with physical therapy and medication. According to a primary treating physician's initial report dated November 21, 2014, the injured worker presented with complaints of neck, right shoulder and both hands and wrists pain. Diagnoses included cervical spine pain rule out cervical disc herniation; bilateral shoulder pain, rule out rotator cuff pathology; bilateral arm wrist and hand pain, rule out carpal tunnel syndrome. Treatment plan included requests for MRI's of the cervical spine and bilateral shoulders, EMG/NCV studies of the bilateral upper extremities and Kera-Tek gel. According to utilization review dated February 5, 2015, the requests for EMG/NCV (electromyography/nerve conduction studies) bilateral upper extremities are non-certified, citing ACOEM Guidelines. The request for Kera-Tek gel; apply thin layer to affected area 2-3 times daily, 4oz. is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Flexeril 10mg; one PO TID PRN #90 is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV bilateral upper extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Table 8-8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

Decision rationale: Based on the 11/21/14 progress report provided by the treating physician, this patient presents with neck pain, right shoulder pain, and bilateral hand/wrist pain. The treater has asked for EMG/NCV BILATERAL UPPER EXTREMITIES on 11/21/14 "to rule out bilateral upper extremity radiculopathy versus carpal tunnel syndrome due to her repetitive typing and hand manipulative movements." The patient's diagnoses per Request for Authorization form dated 12/10/14 are cervical spine pain; r/o disc herniation, bilateral wrist and hand pain; r/o carpal tunnel syndrome, bilateral shoulder pain; r/o rotator cuff pathology, and bilateral arm pain. Review of reports from 8/8/14 to 11/21/14 do not show any evidence that the patient had any prior surgeries to her upper extremities. The patient had a prior EMG/NCV of bilateral upper extremities with demonstrated findings consistent with right wrist carpal tunnel syndrome, sometime before 2005 per 11/21/14 report. The patient describes "increasing symptomatology which she attributes to the performance of her job duties on a continuous trauma basis" per 11/21/14 report. Physical exam on 9/4/14 showed "motor strength graded 4/5 on the right at C4-5. Hypoesthesia on the left at the C7 dermatome." The patient is currently working with restrictions. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between 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." In reference to specialized studies of the neck, MTUS guidelines state that electromyography tests may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Patient presents with possible CTS, radiculopathy, peripheral neuropathy which require electrodiagnostic studies to differentiate. Patient had a prior EMG more than 9 years ago which showed findings consistent with right wrist carpal tunnel syndrome. There is documentation of increased symptoms, and exam findings of radicular symptoms along the C4-5 and C7 dermatomes. The treater is requesting an updated EMG/NCV to rule out upper extremity radiculopathy, which appears reasonable due to patient's industrial exposure on a continuous trauma basis. The request IS medically necessary.

Kera-Tek gel, apply thin layer to affected area 2-3 times daily, 4oz: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topical medications for chronic pain Page(s): 105, 60.

Decision rationale: This patient presents with neck pain, right shoulder pain, and bilateral hand/wrist pain. The treater has asked for KERA-TEK GEL APPLY THIN LAYER TO AFFECTED AREA 2-3 TIMES DAILY, 4 OZ on 11/21/14 "to help with topical myalgias and pain." The patient's diagnoses per Request for Authorization form dated 12/10/14 are cervical spine pain; r/o disc herniation, bilateral wrist and hand pain; r/o carpal tunnel syndrome, bilateral shoulder pain; r/o rotator cuff pathology, and bilateral arm pain. Review of reports from 8/8/14 to 11/21/14 do not show any evidence that the patient had any prior surgeries. The patient has not had prior use of ker-tek gel per review of reports from 8/8/14 to 11/21/14. The patient is currently working with restrictions. Kera-Tek analgesic gel contains MENTHOL 16g in 100g and METHYL SALICYLATE 28g in 100g. Regarding topical analgesics, MTUS states they are largely experimental in use with few randomized controlled trials to determine efficacy or safety, and recommends for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Methyl salicylate and menthol are recommended under MTUS "Salicylate topical" section, page 105 in which "Ben-Gay" (which contains menthol and methyl salicylate) is given as an example and is stated as significantly better than placebo in chronic pain. Topical NSAIDs are indicated for peripheral joint arthritis/tendinitis problems. "Indications: 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." In this case, the patient has chronic pain of the neck, right shoulder, and bilateral wrist/hands. As the patient is not currently using Kera-tek gel, a trial of Kera-tek for patient's peripheral joint arthritis would appear reasonable. Regarding medications for chronic pain, MTUS pg. 60 states treater must determine the aim of use, potential benefits, adverse effects, and patient's preference. Only one medication should be given at a time, a trial should be given for each individual medication, and a record of pain and function should be recorded. The requested trial of Ker-tek gel for to treat patient's myalgias and pain, appears reasonable. The request IS medically necessary.

Flexeril 10mg; one PO TID PRN #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: This patient presents with neck pain, right shoulder pain, and bilateral hand/wrist pain. The treater has asked for FLEXERIL 10MG; ONE PO TID PRN #90 on 11/21/14. The patient's diagnoses per Request for Authorization form dated 12/10/14 are cervical spine pain; r/o disc herniation, bilateral wrist and hand pain; r/o carpal tunnel syndrome, bilateral shoulder pain; r/o rotator cuff pathology, and bilateral arm pain. Review of reports from 8/8/14 to 11/21/14 do not show any evidence that the patient had any prior surgeries. The patient is using Flexeril continuously in 8/8/14, 8/29/14, 9/4/14, and 11/21/14 reports. The patient is currently working with restrictions. MTUS Chronic Pain Medical Treatment Guidelines pg 63-66, "Muscle relaxants (for pain)" under ANTISPASMODICS: Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available) Dosing states: "This medication is not recommended to be used for

longer than 2-3 weeks." MTUS further states: "Effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence." The available records show the patient has been using Flexeril for longer than 3-weeks which exceeds MTUS recommendations. In addition, the patient does not complain of any exacerbations of back pain, which this medication is for. The continued use of Flexeril 7.5mg, #60 IS NOT medically necessary.