

Case Number:	CM15-0037918		
Date Assigned:	03/06/2015	Date of Injury:	06/14/2013
Decision Date:	04/21/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/27/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 54 year old female, who sustained an industrial injury on 06/14/2013. On provider visit dated 01/26/2015 the injured worker has reported cervical spine and bilateral shoulder pain. The diagnoses have included C5-6 disc herniation, chronic right trapezius strain, bilateral shoulder strain and upper extremity overuse syndrome and chronic lumbar strain. Treatment to date has included rest and medication. On examination of the cervical spine and left shoulder revealed to tenderness to palpation. On 01/30/2015 Utilization Review non-certified EMG/NCV of bilateral upper extremities QTY 1, Kera-Tek analgesic gel QTY 1, Flurbiprofen/Lidocaine cream (20%/5%)180gm QTY 1 and modified Physical Therapy twice weekly QTY 12. The CA MTUS, ACOEM Chronic Pain Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of bilateral upper extremities QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve Conduction Velocity Testing (2010).

Decision rationale: According to the ODG, EMG (Electromyography) and nerve conduction studies (NCS) are an extension of the physical examination. EMGs and NCSs are generally accepted, well-established and widely used for aiding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies (e.g. CTS), radiculopathies, and muscle disorders. The California MTUS/ACOEM Guidelines state that EMG and NCVs, including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. In this case, the patient had an EMG/NCV on 6/23/14. There has been no evidence since that time documenting that this patient got acutely worse, or that additional diagnostic testing would alter the course of treatment. Per CA MTUS guidelines, additional diagnostic tests are not indicated. Medical necessity for the requested EMG/NCV of bilateral upper extremities has not been established. The requested studies are not medically necessary.

Kera-Tek analgesic gel QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape (2014).

Decision rationale: Kera-Tek analgesic gel is an over-the-counter topical gel solution. It contains Methyl Salicylate and Menthol. This topical analgesic is not a standard treatment for bilateral shoulder and upper extremity pain, and chronic lumbar strain. There is no peer-reviewed literature to support its use. There is no documentation of functional benefit with this topical agent. It is evident from the records that the patient is able to use oral medications and there is no rationale provided for the use of topical gel. Medical necessity for the requested topical analgesic gel has not been established. The requested topical analgesic is not medically necessary.

Flurbiprofen/Lidocaine cream (20%/5%)180gm QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topical, Topical Analgesics Page(s): 105 and 111-113.

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are

compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound is Flurbiprofen 20%/Lidocaine 5% cream. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). In addition, there is no documentation of intolerance to other previous oral medications. The medical necessity of the requested compounded medication has not been established. The requested topical analgesic compound is not medically necessary.

Physical Therapy twice weekly QTY 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PT Cervical Spine PT Lumbar Spine, Physical Medicine PT Shoulders and Wrists Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. There is no specific indication for the additional 12 PT (2x6) sessions requested, and the additional visits exceed the MTUS and ODG guidelines. Medical necessity for the additional PT visits requested, have not been established. The requested services are not medically necessary.