

Case Number:	CM15-0082609		
Date Assigned:	05/05/2015	Date of Injury:	12/19/2011
Decision Date:	06/24/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	04/29/2015

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 60-year-old male, who sustained an industrial injury on 12/19/2011. The current diagnoses are right carpal tunnel syndrome, status post right shoulder surgery with significant shoulder atrophy (frozen shoulder), and positive scapular winging with positive long thoracic nerve injury, cervical radiculopathy at C5 and C6, and cervical discogenic disease. According to the progress report dated 3/25/2015, the injured worker complains of pain in the cervical spine and right upper extremity associated with weakness and paresthesia. The pain was not rated. Examination of the cervical spine reveals spasms across C6 distribution on the right and decreased range of motion. There is facet tenderness. Positive Hoffman on the right was noted. The current medications are ibuprofen. Treatment to date has included medication management, X-rays, arm sling, MRI studies, physical therapy, electro diagnostic testing, and surgical intervention. The plan of care includes prescription for Flurbiprofen 20% Lido cream, Genocin, Somnacin, EMG/NCS of the bilateral upper extremities, and cervical facet block, bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluriporfen 20% Lido cream: Upheld

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

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. The requested topical analgesic compound for this patient contains Flurbiprofen and Lidocaine. The MTUS guidelines state that Flurbiprofen is not FDA approved for use as a topical application. Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) is FDA approved for neuropathic pain, and used off-label for diabetic neuropathy. No other Lidocaine topical creams or lotions are indicated for neuropathic or non-neuropathic pain. Medical necessity for the topical analgesic cream has not been established. The requested medication is not medically necessary.

Genocin 500 mg #60: Upheld

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

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

Decision rationale: According to the ODG, Genicin (glucosamine) is not recommended for the treatment of low back pain. Glucosamine is not significantly different from placebo for reducing pain-related disability or improving health-related quality of life in patients with chronic low back pain (LBP) and degenerative lumbar osteoarthritis, and it should not be recommended for patients with lower back pain. Glucosamine is a precursor molecule involved in building tendons, ligaments, and cartilage. It is hypothesized to restore cartilage and to have anti-inflammatory properties, and, despite conflicting data on its efficacy, has become widely used as a treatment for osteoarthritis. It has also become more widely used for LBP, including degenerative lumbar osteoarthritis. In this case, the patient has chronic neck pain and there is no indication for the use of Genicin in the treatment of chronic neck pain. Medical necessity for the requested medication has not been established. This medication is not medically necessary.

Somnacin 100 mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic pain, Insomnia treatment.

Decision rationale: According to the ODG, melatonin is recommended for insomnia treatment. Melatonin also has an analgesic effect in patients with chronic pain. Somnicin contains melatonin, 5-HTP, L-tyrptopan, Vitamin B6 and magnesium. The documentation does not indicate that this patient has a sleep disturbance. Medical necessity for the requested item has not been established. The requested medication is not medically necessary.

EMG/NCS of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve Conduction Velocity Testing.

Decision rationale: The request for diagnostic test EMG/NCV for bilateral upper extremities is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, 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. The ODG further states that nerve conduction studies are recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms based on radiculopathy. In this case, the patient underwent electro diagnostic testing on 6/19/14 which revealed evidence of severe trauma to the right axial nerve, the right radial sensory nerve action potential was absent, absent right radial nerve response to posterior cord of the brachial plexus, no evidence of reinnervation in the right deltoid, and mild stretch injury to the posterior cord of the brachial plexus. The documentation indicates there is muscle atrophy in the right shoulder. There is no specific indication for any additional studies at this time. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.

Cervical facet block, bilaterally: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174, 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), forearm, wrist, and hand (acute and chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cervical facet injections.

Decision rationale: According to ODG, cervical facet injections are limited to chronic cervical pain that is non-radicular in nature. There should not be a history of spinal stenosis or previous fusion. There should be documentation of the failure of conservative measures prior to the procedure for at least 4-6 weeks. No more than 2 levels should be injected at any one time. There should also be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. In this case, there is evidence of radicular pain (C5-C6) and no documentation of any response to conservative treatments (PT, cervical traction or home exercise program). There is no specific indication for the requested service at this time. Medical necessity for the requested injections has not been established. The requested facet joint injections are not medically necessary.