

Case Number:	CM15-0091219		
Date Assigned:	05/15/2015	Date of Injury:	07/21/2010
Decision Date:	07/01/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/12/2015

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, Pain Management

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 47 year old female who reported an industrial injury on 7/21/2010. Her diagnoses, and/or impressions, are noted to include: cervical disc herniation; right carpal tunnel syndrome; and right upper extremity radicular pain. Recent computed tomography studies were stated to have been done on 8/29/2014, magnetic resonance imaging studies were stated to have been done in 2012 and again in 2014, and electromyogram studies of the upper extremities were stated to have been done in 2014. The history notes a claim for injuries to the left shoulder. Her treatments have included physical therapy; hand braces; rest from work before return to modified work duties; and pain management. The progress notes of 3/12/2015 reported complaints of the onset of pain in the right side of her neck, right wrist and hand; apparently radiating from her cervical spine. She reports constant neck pain/weakness that radiated into the right shoulder and upper extremity, and was associated with numbness/tingling in the right hand/fingers. This pain was stated to be aggravated by activity and was rated to be severe. Continued complaints included: right shoulder pain with popping, sticking, grinding, and instability, swelling, numbness, tingling, and burning; aggravated by activity. She reported constant right wrist/hand pain, numbness, tingling, hand swelling, loss of grip strength and sensation, rated severe and aggravated by activity. Finally, she reported constant lower back pain that occasionally radiated into the right hip, rated as moderate-severe, and aggravated by activity. This pain was stated to have been a result of performing her normal and customary duties. The objective findings were noted to include cervical spine tenderness with decreased range-of-motion, and positive compression test; tenderness with decreased range-of-motion to the bilateral shoulders with

positive bilateral Neer's & Hawkins impingement tests; tenderness with decreased range-of-motion of the bilateral wrists with positive Finkelstein's test on the right, positive Phalen's test bilaterally; tenderness, hyper-tonicity, and decreased range-of-motion to the bilateral lumbar spine with positive Minor's sign. The physician's requests for treatments were noted to include magnetic resonance imaging studies of the cervical spine, Keratek analgesic Gel and Lidoderm Patches for continued chronic pain affecting her cervical spine and right upper extremity which has been intolerant to therapy, activity restrictions and medications, and to restore her activity levels and functional restoration, allowing her to continue gainful employment.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-7. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, MRI Topic.

Decision rationale: Regarding the request for repeat cervical MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. The ODG stipulate that repeat studies should be reserved for a significant change in pathology. Within the documentation available for review, there is no indication of any red flag diagnoses. However, the progress note do suggest continued neck pain and radicular symptoms. An electrodiagnostic study has already been certified and is the initial test of choice per ACOEM for identifying subtle neurologic deficits. This should be carried out prior to cervical MRI in this case. The requested cervical MRI is not medically necessary.

Ergonomic Workstation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 1 Prevention.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention.

Decision rationale: Regarding the request for workstation ergonomic workstation, ACOEM Practice Guidelines state that engineering controls, including ergonomic workstation evaluation and modification, and job redesign to accommodate a reasonable proportion of the workforce may well be the most cost effective measure in the long run. Within the documentation available for review, it is unclear exactly what ergonomic problems are present at the patient's worksite. The patient is working at a computer desk the vast majority of the time. But the requesting physician has not identified what type of biomechanical issues he feels is contributing to the

patient's ongoing symptoms. In the absence of clarity regarding those issues, the currently requested ergonomic workstation is not medically necessary. However, I do feel is appropriate to have an ergonomic evaluation as specified by the utilization review determination.

Kera-Tek analgesic gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Biofreeze and Cryotherapy gel.

Decision rationale: Keratek is a mixture of methyl salicylate and menthol. The CPMTG requires that all components of a compounded mixture be appropriate in order for the compound to be recommended. There are no provisions for topical menthol in the California Medical Treatment Utilization Schedule. Therefore the Official Disability Guidelines are referenced, which support the use of menthol only in the context of acute low back pain as an alternative to ice packs. Specifically, the Official Disability Guidelines Low Back Chapter under the Biofreeze and Cryotherapy section state: "Recommended as an optional form of cryotherapy for acute pain. See also Cryotherapy, Cold/heat packs. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication. This randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group. (Zhang, 2008)" Given that this worker does not have documentation of acute low back pain, and that the progress note from March 2015 indicate the application site is wrists/hands, the topical menthol is not medically necessary. Thus, the entire formulation is not medically necessary.

Lidoderm patches 5% (generic brand OTC medication preferred), quantity 60 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Non Steroidal Anti Inflammatory Drugs, Lidocaine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical lidocaine Page(s): 112.

Decision rationale: Regarding request for topical Lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the first line therapy such as tricyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of localized peripheral neuropathic pain in the area of application as recommended by guidelines. The documentation indicates this is for the cervical spine and wrist. While there is documented

carpal tunnel affecting the wrist, the cervical spine does not have a localized neuropathic process. Cervical radiculopathy is not considered a localized neuropathic pain process as it affects large dermatomes. It has not been proven efficacious in clinical trials that Lidoderm helps with cervical radiculopathy. As such, the currently requested Lidoderm is not medically necessary.