Case Number:	CM13-0024433		
Date Assigned:	11/20/2013	**Date of Injury:**	03/28/2008
Decision Date:	01/14/2014	**UR Denial Date:**	08/14/2013
Priority:	Standard	**Application Received:**	09/13/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesia, 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 physician 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 39 y/o male injured worker with DOI of 3/28/2008 has been diagnosed with contact dermatitis of the hands. This has resulted in blistering, open wounds, and purities. Nickel and cadmium patch testing has yielded both positive and negative results in the past. Dermatologist requested laser treatment for this but treatment was denied. Refractory to multiple topical regimens, including first line agents. Repeat testing was ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Three (3) patch nickel and cadmium test: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Bourke J, Coulson I, English J, British Association of Dermatologists Therapy Guidelines and Audit Subcommittee. Guidelines for the management of contact dermatisis: an update. Br J Dermatol. 2009 May;160 (5):946-54. [64 references] .

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Torres et al. "Management of contact dermatitis due to nickel allergy: an update" Clin Cosmet Investigating Dermatol. 2009; 39-48..

Decision rationale: The MTUS, ACOEM, ODG, and other guidelines are silent on repeat testing as has been requested. The UR physician's rationale for denial of testing points out that treatment has been the same after the patient's previous positive test and previous negative test. However, there have been other treatments proposed (ie laser treatment) which have been denied, and other possible treatments to pursue, and the assessment of risk vs benefit for pursuing these treatments can be informed by more data to help characterize the diagnosis. Based upon the citation referenced above, "There is a high degree of concordance between history of nickel exposure and outcome of patching testing.68, 69. Nickel is the most common positive patch test allergen. It has been estimated that nickel-positive tests are seen in 10% to 30% of female patients, 2% to 8% of male patients, 15.9% of children and 13.7% of patients older than 65, but it varies greatly, depending on the selected population.7, 70, 71 Although sensitivity and sensibility of patch testing is not exactly known, reproducibility is generally high, even though results may vary in the same patient at different times.72-74. The standard patch test concentration of nickel sulfate is 5% pet in Europe and 2.5% pet in the USA. Positive reactions are usually strong. False-positive reactions may occur in atopics, where follicular irritative reactions are common. Weak true-positive reactions can also show a follicular pattern. False-negative reactions can also occur. In case of strong clinical suspicion, the test can be repeated with nickel chloride 5%, which increases nickel concentration, by using penetration enhancers such as dimethyl sulfoxide (DMSO) or scratching the skin before patch test application. Since patch tests are often performed by different specialists including allergists, dermatologists, pediatricians, and general physicians, special training is essential to correctly judge and interpret the test in order to distinguish allergic from irritative reactions and establish patch test relevance."