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| Case Number: | CM13-0029025 | | |
| Date Assigned: | 03/21/2014 | Date of Injury: | 05/11/2013 |
| Decision Date: | 04/29/2014 | UR Denial Date: | 09/23/2013 |
| Priority: | Standard | Application Received: | 09/24/2013 |

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. The expert reviewer is Board Certified in Family Practice, and is licensed to practice in Texas. 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/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:

The patient is a 56-year-old who reported an injury on May 11, 2013. The patient was reportedly injured when she was struck on the left upper extremity by a client's family member. The patient is currently diagnosed with left shoulder sprain and strain with possible impingement syndrome, left wrist sprain and strain with tendonitis, possible posttraumatic De Quervain's disease in the left wrist, and psychological sequelae. The most recent physician progress report submitted for this review is document don July 2, 2013, by [REDACTED]. The patient reported persistent complaints of left shoulder pain and stiffness with radiation to the left side of the neck as well as left arm, wrist, and hand pain. The patient also reported anxiety, depression, stress, and difficulty sleeping. Physical examination revealed tenderness to palpation over the tip of the acromion and supraspinatus tendon, positive impingement testing on the left, limited left shoulder range of motion, tenderness to palpation over the dorsal radiocarpal joint and first dorsal compartment, negative Tinel's and Phalen's testing, equivocal Finkelstein's testing, limited left wrist range of motion, intact sensation, and reduced grip strength on the left. Treatment recommendations at that time included prescriptions for Anaprox and Prilosec, as well as physical therapy and an MRI of the left wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG OF THE RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines state electromyography and nerve conduction velocities may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms lasting more than three or four weeks. As per the documentation submitted, the patient reported persistent pain in the left upper extremity. Physical examination revealed negative Tinel's and Phalen's testing as well as intact sensation. There was no documentation of a significant neurological deficit with regard to the right upper extremity. There is also no mention of an attempt at conservative treatment prior to the request for an electrodiagnostic study. The patient is currently pending a course of conservative treatment consisting of physical therapy, symptomatic medications, and topical ointments. The request for an EMG of the right upper extremity is not medically necessary or appropriate.

NCV OF THE RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: California MTUS/ACOEM Practice Guidelines state electromyography and nerve conduction velocities may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms lasting more than 3 or 4 weeks. As per the documentation submitted, the patient reported persistent pain in the left upper extremity. Physical examination revealed negative Tinel's and Phalen's testing as well as intact sensation. There was no documentation of a significant neurological deficit with regard to the right upper extremity. There is also no mention of an attempt at conservative treatment prior to the request for an electrodiagnostic study. The patient is currently pending a course of conservative treatment consisting of physical therapy, symptomatic medications, and topical ointments. The request for an NCV of the right upper extremity is not medically necessary or appropriate.

REFERRAL TO A QUALIFIED MENTAL HEALTH PROFESSIONAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The Cornerstones of Disability Prevention and Management Chapter of the ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. Although the patient does report symptoms of anxiety, depression, stress, and insomnia, there is no evidence of a comprehensive psychological examination prior to the request for a specialty referral. Therefore, the medical necessity has not been established. The request for a referral to a qualified mental health professional is not medically necessary or appropriate.

ANAPROX (NO DOSAGE OR QUANTITY GIVEN): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state NSAIDs (non-steroidal anti-inflammatory drugs) are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. This is a nonspecific request that does not include a dosage, frequency, or quantity. The request for Anaprox is not medically necessary or appropriate.

PRILOSEC (NO DOSAGE OR QUANTITY GIVEN): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. This is a nonspecific request that does not include the dosage, quantity, or frequency. The request for Prilosec is not medically necessary or appropriate.

MEDROX PATCHES (NO DOSAGE OR QUANTITY GIVEN): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few, randomized controlled trials to determine efficacy or safety. This is a nonspecific request and does not include the dosage, frequency, or quantity. The request for Medrox is not medically necessary or appropriate.