

Case Number:	CM14-0120927		
Date Assigned:	08/06/2014	Date of Injury:	07/16/2002
Decision Date:	09/12/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/31/2014

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 Anesthesiology, 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 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 injured worker is a 59 year old male who had a work related injury on 07/16/02. Mechanism of injury was not documented. Two most recent clinical documentations submitted for review was 05/08/14 and 06/19/14 both illegible. Clinical record dated 03/27/14 the patient presented with multiple orthopedic complaints including bilateral forearm and wrist pain with numbness and tingling radiating to the fingers. The injured worker failed to improve in response to previous conservative treatment including supervised therapy, medication, bracing, activity modification, acupuncture treatment, and home therapy regimen. On follow up examination of 03/25/14 her continuing complaints included persistent left hand pain with weakness and increased with pushing pulling, gripping, grasping, and tightening. Previous diagnostic ultrasound finding of bilateral hands obtained on 02/06/14 showed evidence of distinct nerve sheath nodule just beneath the skin surface located slightly proximal from the metacarpal phalangeal joint within the thenar eminence of the left hand. Small nerve sheath nodule revealed mild fibrotic changes and traced edema representing neuroma. Right hand was evaluated for comparison was found it was small fluid filled cystic lesion consistent with ganglion cyst along the volar aspect of the metacarpal phalangeal joint. Prior utilization review on 07/08/14 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ativan 2mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use due to lack of proven efficacy with prolonged use and the risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The patient has exceeded the 4 week treatment window. As such, the request for this medication cannot be recommended at this time.

Lidoderm patch 5% #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

Decision rationale: As noted on page 56 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an anti-epileptic drugs such as gabapentin or Lyrica). Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Therefore this compound cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

X-Rays , three views, bilateral thumbs: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 11-1, 11-7.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand and wrist chapter, Radiography.

Decision rationale: The request for X-Rays , three views, bilateral thumbs is not medically necessary. The clinical documentation submitted for review does not support the request. The

documentation submitted did not offer any clinical rationale for the need for x-rays. As such, medical necessity has not been established.

EMG, bilateral upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: The request for electromyogram, bilateral upper extremities is not medically necessary. The clinical documentation submitted for review does not support the request for the study. There is no clinical evidence submitted that reflects any neurological deficits on physical examination. As such, medical necessity has not been established.

NCV, bilateral upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The request for nerve conduction velocity, bilateral upper extremities is not medically necessary. The clinical documentation submitted for review does not support the request for the study. There is no clinical evidence submitted that reflects any neurological deficits on physical examination. As such, medical necessity has not been established.

Interferential stimulator and necessary supplies for long term use, Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Inteferential Current Stimulataion.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The request for Interferential stimulator and necessary supplies for long term use, purchase is not medically necessary. The current evidence based guidelines do not support the request. Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There is no documentation that the injured worker had a 1 month trial and the effects or benefits of the trial, therefore medical necessity has not been established.