

Case Number:	CM14-0029775		
Date Assigned:	06/20/2014	Date of Injury:	12/19/2013
Decision Date:	07/25/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/09/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Minnesota. 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 44 year old female who reported an injury on 12/19/2013 due to emotional stress within the work place. The injured worker's diagnoses included depressive disorder, anxiety disorder and primary insomnia. The injured worker's treatment history included pharmacological intervention and psychological support. The patient was evaluated on 01/28/2014. It was documented that the patient had bilateral wrist pain rated at a 7/10 and shoulder pain radiating into the bilateral upper extremities. The physical findings included tenderness to palpation of the acromioclavicular joint and painful range of motion of the right shoulder with a positive Neer's test and left shoulder undocumented tenderness to palpation over the acromioclavicular joint. An evaluation of the right elbow documented tenderness to palpation over the lateral epicondyle of the right elbow and tenderness to palpation over the elbow joint of the left elbow. The evaluation of the right wrist documented a positive Tinel's sign and a positive Phalen's sign. The patient's diagnoses included depressive disorder, anxiety disorder, insomnia related to anxiety disorder and stress related psychological response affecting headaches. A request for authorization was submitted on 03/09/2014 for genetic testing, Lidocaine cream, elbow braces, x-rays of the bilateral shoulders, x-rays of the elbows, x-rays of the wrists and hands, night splints for the bilateral wrists, electrodiagnostic studies for the upper extremities, 12 physical therapy appointments and unspecified topical and oral medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Genetic Testing: 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) Pain chapter, Genetic testing for potential opioid abuse.

Decision rationale: The requested genetic testing is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines do not recommend genetic testing as it is considered experimental and investigational and is not supported by scientific evidence. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Additionally, the clinical documentation does not provide any evidence of medications that are being provided to the patient that have addictive properties. As such, the requested genetic testing is not medically necessary or appropriate.

Prescription of Xolido (Lidocaine HCL Cream), #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

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

Decision rationale: The requested Xolido (Lidocaine HCL cream) #1 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the use of Lidocaine in a cream formulation as it is not FDA approved to treat neuropathic pain. The clinical documentation submitted for review does not provide any exceptional factors to support extending treatment beyond guideline recommendations. Additionally, the request, as it is submitted, does not clearly identify a dosage, quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the prescription of Xolido (Lidocaine HCL cream) #1 is not medically necessary or appropriate.

Elbow Braces, #2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 26.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 20-21.

Decision rationale: The requested elbow braces #2 is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine states that initial care for the elbows should include nonprescription analgesics for acute and subacute elbow symptoms. Additional treatment should be provided if there is an inadequate response to nonprescription

analgesics. The clinical documentation submitted for review does not clearly identify that the patient has not responded to nonprescription analgesics and requires further conservative treatment.

X-rays of the bilateral shoulders, #2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The requested x-rays of the bilateral shoulders, #2 is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not recommend special studies until there has been a period of conservative care and observation that has failed to provide improvement in symptoms. The clinical documentation fails to provide any evidence that any conservative treatment has been provided for this injured worker and additional diagnostic studies are required. As such the requested x-rays of the bilateral shoulders, #2 is not medically necessary or appropriate.

X-Rays of the elbows, qty: 2.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42-43.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42-43.

Decision rationale: The requested x-rays of the elbows, qty: 2.00 are not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not recommend special studies until there has been a period of conservative care and observation that has failed to provide improvement in symptoms. The clinical documentation fails to provide any evidence that any conservative treatment has been provided for this injured worker and additional diagnostic studies are required. As such the requested x-rays of the elbows, qty: 2.00 are not medically necessary or appropriate.

X-Rays of the wrists and hands, qty: 2.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: The requested x-rays of the wrists and hands, qty: 2.00 are not medically necessary or appropriate. The American College of Occupational and Environmental Medicine

does not recommend special studies until there has been a period of conservative care and observation that has failed to provide improvement in symptoms. The clinical documentation fails to provide any evidence that any conservative treatment has been provided for this injured worker and additional diagnostic studies are required. As such the requested x-rays of the wrists and hands, qty: 2.00 are not medically necessary or appropriate.

Night Splints for the bilateral wrists, qty: 2.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 263-264.

Decision rationale: The requested night splints for the bilateral wrists, qty: 2.00 are not medically necessary or appropriate. The American College of Occupational and Environmental Medicine states that initial care for the wrists should include nonprescription analgesics for acute and subacute wrist symptoms. Additional treatment should be provided if there is an inadequate response to nonprescription analgesics. The clinical documentation submitted for review does not clearly identify that the patient has not responded to nonprescription analgesics and requires further conservative treatment.

Electromyogram (EMG) for the Right Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

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

Decision rationale: The requested electromyogram (EMG) of the right upper extremity is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not recommend the use of electrodiagnostic studies unless there has been a period of observation and conservative care. The clinical documentation fails to provide any evidence that the patient has received any conservative treatment to the bilateral upper extremities or cervical spine and would benefit from additional diagnostic studies. As such, the requested electromyogram (EMG) for the right upper extremity is not medically necessary or appropriate.

Electromyogram (EMG) for the Left Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

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

Decision rationale: The requested electromyogram (EMG) of the left upper extremity is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not recommend the use of electrodiagnostic studies unless there has been a period of observation and conservative care. The clinical documentation fails to provide any evidence that the patient has received any conservative treatment to the bilateral upper extremities or cervical spine and would benefit from additional diagnostic studies. As such, the requested electromyogram (EMG) for the left upper extremity is not medically necessary or appropriate.

Nerve Conduction Study (NCS) of the Right Upper Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The requested nerve conduction study (NCS) of the right upper extremity is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not recommend the use of electrodiagnostic studies unless there has been a period of observation and conservative care. The clinical documentation fails to provide any evidence that the patient has received any conservative treatment to the bilateral upper extremities or cervical spine and would benefit from additional diagnostic studies. As such, the requested nerve conduction study (NCS) for the right upper extremity is not medically necessary or appropriate.

Nerve Conduction Study (NCS) of the Left Upper Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The requested nerve conduction study (NCS) of the left upper extremity is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not recommend the use of electrodiagnostic studies unless there has been a period of observation and conservative care. The clinical documentation fails to provide any evidence that the patient has received any conservative treatment to the bilateral upper extremities or cervical spine and would benefit from additional diagnostic studies. As such, the requested nerve conduction study (NCS) for the left upper extremity is not medically necessary or appropriate.

Trial of 12 physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested trial of 12 physical therapy sessions is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend physical therapy to address pain complaints, weakness deficits and range of motion deficits. The clinical documentation submitted for review does indicate that the patient has multiple body part pain complaints that may benefit from a course of physical therapy. However, the California Medical Treatment Utilization Schedule recommends up to 8 to 12 visits for radicular, neuropathic and myopathic pain. The request exceeds this recommendation. There are no exceptional factors noted to extend treatment beyond guideline recommendations. Furthermore, the request, as it is submitted, does not specifically identify a body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested trial of 12 physical therapy sessions is not medically necessary or appropriate.

Topical Compounds and Oral Medication Unspecified: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Topical Analgesics and Medications for Chronic Pain Page(s): 111 and 60.

Decision rationale: The requested topical compounds and oral medications unspecified are not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the use of topical analgesics as they are largely experimental and not supported by scientific evidence. The California Medical Treatment Utilization Schedule does recommend the use of medications in the management of chronic pain. However, the request, as it is submitted, does not specifically identify medications or components of the requested topical compound. Furthermore, the request does not specifically identify dosage, frequency or quantity of these medications. The appropriateness of the request itself cannot be determined. As such, the requested topical compounds and oral medications unspecified are not medically necessary or appropriate.