MAXIMUS Federal Services

Case Number:	CM14-0077157		
Date Assigned:	07/18/2014	Date of Injury:	02/10/2012
Decision Date:	09/24/2014	UR Denial Date:	05/01/2014
Priority:	Standard	Application Received:	05/27/2014

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 and Rehabilitation and is licensed to practice in New York and 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 injured worker is a 50 year old female who is reported to have sustained injuries to her right wrist on 02/10/12. It is reported that she began to develop right wrist pain secondary to the movement and use of licensing manuals. Records indicate that the injured worker was diagnosed with a TFCC tear. She ultimately has undergone 2 surgeries to the right wrist, the first being on 12/14/12 and the second on 09/13/13. She is additionally noted to have undergone a left wrist surgery on 04/05/13. Postoperatively, she reports no benefit. She was later reported to have developed a right wrist reflex sympathetic dystrophy for which she received stellate ganglion blocks. It is reported that she received 100% relief for 2 days. On 04/18/14, she was referred for psychiatric evaluation. The evaluator recommends that the injured worker undergo individual psychotherapy for depression and other conditions secondary to her diagnosis of reflex sympathetic dystrophy. The record contains a utilization review determination dated 05/23/14 in which a request for a spinal cord stimulator implant and compound cream 10% Diclofenac and 10% Lidocaine was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal Cord Stimulator implant: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Spinal cord stimulators Page(s): 105-107.

Decision rationale: The request for a spinal cord stimulator implant is not medically necessary. The submitted clinical record indicates that the injured worker has a diagnosis of right wrist reflex sympathetic dystrophy validated by examination and temporary response to stellate ganglion blocks. As a requirement for a spinal cord stimulator implant, there must be a preoperative psychiatric evaluation approving the injured worker for a spinal cord stimulator trial. Per the psychiatric note dated 04/18/14, the injured worker has significant depression secondary to her injuries and familial issues and as such, has been recommended to undergo individual psychotherapy. The record fails to clear the injured worker for a trial. It would further be noted that prior to the permanent implantation of a spinal cord stimulator, the injured worker must undergo a trial with documentation of appropriate relief prior to the approval for permanent implantation. The record contains no data to establish that a trial has been performed and that the injured worker meets criteria and therefore, medical necessity is not established.

Topical Compound Cream 10% diclofenac, 10% lidocaine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compounded Medications.

Decision rationale: The request for a topical compound cream 10% Diclofenac, 10% Lidocaine is not medically necessary. The submitted clinical records indicate that the injured worker has right upper extremity reflex sympathetic dystrophy which is an adverse side effect of this topical cream and therefore not recommended by the guidelines.