

Case Number:	CM15-0142144		
Date Assigned:	08/03/2015	Date of Injury:	06/29/2009
Decision Date:	09/29/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/22/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

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 49 year old female, who sustained an industrial injury on 6-29-09. She reported left shoulder pain and numbness in right hand due to computer use, reaching, grasping and pulling at work. The injured worker was diagnosed as having shoulder pain and rotator cuff tear arthropathy. Treatment to date has included Transcutaneous electrical nerve stimulation (TENS) unit, ice, activity restrictions, brace, carpal tunnel release, 6 psychotherapy sessions, home exercise program, aqua therapy, myofascial release, home exercise program, oral medications including Ativan 1mg, Celexa 20mg, Cymbalta 60mg, Lyrica 50mg, Nabumetone 500mg, Naprosyn 250 mg and Topiramate 50mg and Voltaren 1% topical gel. Currently on 6-24-15, the injured worker complains of chronic left shoulder pain, left elbow pain, left arm pain, left wrist pain and left hand pain rated 8 out of 10, which is unchanged from previous visit. Physical exam performed on 6-24-15 revealed anxious and depressed female with guarded movements of upper extremities. The treatment plan and a request for authorization were submitted for (EMG) Electromyogram, (NCV) Nerve Condition Velocity, behavioral psychotherapy, Lyrica and Voltaren 1% topical gel.

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): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, wrist, and hand chapter, Electrodiagnostic studies (EDS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

Decision rationale: CA MTUS guidelines recommend (EMG) Electromyogram studies to confirm a diagnosis of carpal tunnel syndrome. If these tests are performed in the early stages and are mild, they may be repeated later if symptoms persist. The current request is for (EMG) Electromyogram of right upper extremity. The injured worker had no complaints of the right upper extremity. In this case, the request is not medically necessary due to no symptoms regarding the right upper extremity.

NCS of the right upper extremity, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, wrist, and hand chapter, Electrodiagnostic studies (EDS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

Decision rationale: CA MTUS guidelines recommend (NCV) Nerve Condition Velocity studies to confirm a diagnosis of carpal tunnel syndrome. If these tests are performed in the early stages and are mild, they may be repeated later if symptoms persist. The current request is for (NCV) Nerve Condition Velocity of right upper extremity. The injured worker had no complaints of the right upper extremity. In this case, the request is not medically necessary due to lack of symptoms regarding the right upper extremity.

Behavioral Psychotherapy, QTY: 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress Chapter, Psychotherapy for MDD (major depressive disorder); Psychotherapy Guidelines; Group Therapy; Pain Chapter, Psychological treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress, psychotherapy.

Decision rationale: ODG guidelines recommend psychotherapy for 6 visits over 6 weeks initially and 13-20 visits over 7-20 weeks (individual sessions) if progress is being made). Symptom improvement should be evaluated so alternative treatment strategies can be pursued.

Studies have shown that 4-6 sessions should be sufficient to provide evidence of symptom improvement. In this case, the injured worker has completed the initial 4 of 4 visits. The documented discussion states she has completed the sessions and would benefit from continuation and she was given information on the art program. The medical necessity of the continued treatments is not documented. Therefore, the request is not medically necessary.

Voltaren 1% gel 100gm, QTY: 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Voltaren Gel (Diclofenac).

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

Decision rationale: According to the California MTUS Guidelines, Voltaren Gel 1% (Diclofenac) is indicated for the relief of osteoarthritis in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The submitted documentation does not indicate that the injured worker had a diagnosis of osteoarthritis. In addition, there was no dosage specified for the requested medication. Medical necessity for the requested topical gel has been not established. The requested 1% Voltaren Gel is not medically necessary.