

Case Number:	CM15-0030451		
Date Assigned:	02/24/2015	Date of Injury:	03/07/2008
Decision Date:	04/21/2015	UR Denial Date:	02/16/2015
Priority:	Standard	Application Received:	02/18/2015

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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 65-year-old female, who sustained an industrial injury on March 7, 2008. The initial symptoms reported by the injured worker were not included in the medical record. The injured worker was diagnosed as having right shoulder pain, degenerative cervical disc disease, lateral epicondylitis and tendonitis of the elbow or forearm. Treatment to date has included trigger point injection, medications, acupuncture, physical therapy and TENS unit. On September 23, 2014, the injured worker complained of neck pain, bilateral trapezial pain and right upper extremity pain. The pain is described as an aching in her neck and trapezius. She rated the pain as a 7 on a 1-10 pain scale. She reported the pain to be worse with range of motion of her neck. The pain was noted to get better with injections, physical therapy, acupuncture, heat and ice. The treatment plan includes trigger point injections, Voltaren gel, massage therapy and follow-up visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right wrist x-ray: 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 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official disability guidelines Forearm, Wrist and Hand Chapter on Radiography.

Decision rationale: The patient presents with neck, bilateral trapezius and right upper extremity pain. The physician is requesting RIGHT WRIST X-RAY. The RFA was not made available for review. The patient's date of injury is from 03/07/2008 and she is currently retired. The ACOEM Guidelines Chapter 11 on Forearm, Wrist and Hand Complaints page 268 on x-rays of the wrist and hand states, "For most patients presenting with true hand and wrist problems, special studies are not needed until after 4 to 6 weeks period of conservative care and observation. Most patients improved quickly provided red flag conditions are ruled out." Furthermore, ODG states that for most patients with known or suspected trauma of the hand, wrist, or both, the conventional radiographic survey provides an adequate diagnostic information and guidance to the surgeon. The records do not show any prior x-rays of the right wrist. The 09/23/2014 progress report does not show any right wrist examination. Labor Code 4610.5-2- definition of medical necessity. "Medically necessary" and "medical necessity" meaning medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury. In this case, the medical necessity for a right wrist x-ray has not been established. The request IS NOT medically necessary.

TENS unit purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

Decision rationale: The patient presents with neck, bilateral trapezius and right upper extremity pain. The physician is requesting TENS UNIT PURCHASE. The RFA was not made available for review. The patient's date of injury is from 03/07/2008 and she is currently retired. The MTUS guidelines pages 114 to 116 on TENS unit states that it is not recommended as a primary treatment modality, but a 1-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration. The records do not show any prior TENS unit trial. The report making the request was not made available. While a trial of the TENS unit may be appropriate for this patient, the current request for a TENS unit purchase is not warranted. The request IS NOT medically necessary.

Voltaren 1% gel: Upheld

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

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

Decision rationale: The patient presents with neck, bilateral trapezius and right upper extremity pain. The physician is requesting VOLTAREN 1% GEL. The RFA was not made available for review. The patient's date of injury is from 03/07/2008 and she is currently retired. The MTUS Guidelines page 111 on topical analgesics states that it is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS also states that Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment of osteoarthritis. It is, however, indicated for short term use, between 4-12 weeks. It is indicated for patient with Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The records show that the patient was prescribed Voltaren on 09/23/2014. The 09/23/2014 progress report shows 5/5 bilateral upper extremity strength. DTRs are 2+ and symmetric. Sensation is intact. TTP on the bilateral trapezius and bilateral supraspinatus evidence upon palpation of a twitch response as well as referred pain. There is tenderness over the cervical paraspinals. The patient has a diagnosis of epicondylitis and tendinitis of the elbow. The MTUS Guidelines page 60 and 61 states that pain assessment and functional changes must also be noted when medications are used for chronic pain. Given the lack of documented medication efficacy including functional improvement while utilizing Voltaren gel, the request IS NOT medically necessary.