

Case Number:	CM15-0047683		
Date Assigned:	04/14/2015	Date of Injury:	10/04/2014
Decision Date:	05/29/2015	UR Denial Date:	02/28/2015
Priority:	Standard	Application Received:	03/13/2015

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 51 year old male, who sustained an industrial injury on 10/4/14. He reported multiple lacerations to right hand and pain to chest. The injured worker was diagnosed as having fracture of right hand, myositis of forearms, cervical sprain, thoracic sprain, bilateral carpal tunnel syndrome and tendonitis of bilateral elbows and shoulders. Treatment to date has included repair of right hand lacerations, open reduction and internal fixation of displaced right 5th metacarpal neck fracture, physical therapy, removal hardware of 5th metacarpal, occupational therapy. Currently, the injured worker is status post removal of hardware of 5th metacarpal. A CT of the cervical spine was performed on 10/04/2014 and noted to reveal a normal non-contrast CT of the cervical spine. A right shoulder x-ray performed on 10/06/2014 demonstrated no significant bone or joint abnormality. A right shoulder MRI performed on 10/20/2014 was noted to reveal partial tear of the supraspinatus tendon; mild osteoarthritis on the glenohumeral joint; degenerative changes in the acromioclavicular joint; mild lateral down sloping acromion; and minimal fluid along the biceps tendon suggestive of tendonitis. Physical exam performed on 1/16/15 revealed healed hand wounds, some decreased range of motion of little finger, although slightly improved. Posttraumatic stiffness is noted of right hand. The treatment plan included prescription for Norco, hand therapy and follow up x-rays of hand. An X-ray of the right hand dated 1/16/15 was noted to reveal healed fracture of the distal right fifth metacarpal and near-complete healing of the fracture at the more proximal right fifth metacarpal. A request for authorization was submitted for x-rays of wrists, elbows, shoulders, cervical and

thoracic spine, (EMG) Electromyogram/(NCS)Nerve Condition Velocity studies, TENS unit and orthopedic consult.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic consultation for the upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 210.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254-256, 44-49, 209-210, 179-180.

Decision rationale: The request for orthopedic consultation for the upper extremities is not supported. The CA MTUS/ACOEM Guidelines suggest that shoulder surgery should be reserved for cases failing conservative therapy for 3 months. In regard to the elbow, a referral is indicated in cases where the healthcare provider lacks training in managing the specific symptom, is unclear about the diagnosis or treatment plan, or red flags are present. Referral for a hand surgery consult may be indicated for patients who have red flags of a serious nature, fail to respond to conservative management, clear clinical and special study evidence of a lesion that has been shown to benefit from surgical intervention. Orthopedic consultation for the upper extremities does not appear appropriate at this time. The cited guidelines recommend orthopedic consultation after failing a course of conservative treatment, including an exercise program. The documentation indicated that the injured worker had at least 8 sessions of occupational therapy postoperatively to address his hand. However, it does not demonstrate him having gone through a course of conservative care for the remaining of the upper extremities. Therefore, the request is not medically necessary. The request lacks the actual upper extremities consultation is needed for.

X-rays of the wrists, elbows, shoulders, cervical and thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 272, 268-269, 207-209, 182, 303-305.

Decision rationale: The request for x-rays of the wrist, elbow, shoulder, cervical, and thoracic spine is not supported. The guidelines suggest that cervical and/or thoracic spine x-rays are not needed unless 3 to 4 weeks of conservative care and observation fail to improve symptoms, or in the emergence of red flags. Routine x-rays are not recommended for shoulder, elbow, or wrist complaints prior to 4 to 6 weeks of conservative treatment. X-rays are not indicated at this time.

The documentation submitted show the injured worker had CT scans of his neck and chest, which were found to be normal, and an MRI of the right shoulder, which showed partial tear of the supraspinatus. There was a lack of documentation that the injured worker had any conservative therapy to address his current conditions, other than postoperative occupational therapy to the right hand. The request for x-rays of the wrist, elbow, shoulder, cervical spine, and thoracic spine is not medically necessary.

EMG/NCS of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273, 42-43, 207-209, 177-179.

Decision rationale: The request for EMG/NCS of the bilateral upper extremities is not supported. The CA MTUS/ACOEM Guidelines state special studies are not needed unless there has been at least 4 weeks of conservative care, and observation failed to improve symptoms. An EMG/NCS is not indicated at this time. There is no clear objective findings of neurological symptoms. As such, the request for EMG/NCS of the bilateral upper extremities is not medically necessary.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation.

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

Decision rationale: The request for TENS unit is not supported. The California MTUS Guidelines do not recommend the TENS unit as a primary treatment modality. However, if used as adjunct to a program of evidence based functional restoration, a 1 month home based trial may be considered as a noninvasive option. A TENS unit is not indicated. There was a lack of documentation of chronic intractable pain of specific conditions which the injured worker was diagnosed with, his current pain is of a subacute nature. There was a lack of documentation of frequency during it is to be used. There was a lack of documentation of body part the unit was to be used on. The request for a TENS unit is not medically necessary.

Lidopro 121gm (4 fl oz): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for LidoPro 121 gr, 4 fluid oz, is not supported. The California MTUS Guidelines state any compounded product, such as LidoPro, which is capsaicin, lidocaine salicylate, and menthol, that contains at least 1 drug (or drug class) that is not recommended, is not recommended. Capsaicin is only recommended as an option in those who have not responded, or are intolerant, to other treatments. Lidocaine topicals are indicated for localized peripheral pain after there has been evidence of a trial of a first line therapy. Topical salicylates are indicated for treating an osteoarthritis and tendinitis, particularly in 2 joints amenable to topical treatment, such as knee and elbow. There is no evidence based recommendations regarding the topical application of menthol. LidoPro is not indicated. LidoPro contains menthol, which does not have evidence based recommendation, so it is not recommended. As such, the request for LidoPro 121 gm, 4 fl oz, is not medically necessary.