

Case Number:	CM13-0063431		
Date Assigned:	12/30/2013	Date of Injury:	12/12/2012
Decision Date:	08/01/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/10/2013

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 62-year-old male who reported an injury on 12/12/2012. The mechanism of injury was a crushing injury to his left thumb. The diagnosis included left thumb contusion with functional losses. Previous treatments include medication, twelve (12) sessions of occupational therapy, and home exercise. Within the clinical note dated 11/01/2013, it was reported that the injured worker complained of pain, which affected his left wrist and left hand. Upon the physical examination of the left hand the provider noted there was no erythema or edema. Flexion was limited at 20 degrees at the distal interphalangeal joint at 45 degrees at the proximal interphalangeal joint with limited range of motion. The provider requested diclofenac and occupational therapy to address the limited range of motion. The Request for Authorization was submitted and dated on 11/16/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac 1% gel, apply twice daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112. Decision based on Non-MTUS Citation Voltaren package insert.

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

Decision rationale: The injured worker complained of pain which affected his left wrist and hand. The Chronic Pain Guidelines indicate that topical non-steroidal anti-inflammatory drugs (NSAIDs) are recommended for the use of osteoarthritis and tendonitis in particular that of the knee and elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of four to twelve (4 to 12) weeks. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The guidelines also note that the FDA approved agents, diclofenac, are indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment including ankle, elbow, foot, hand, knee, and wrist. There is a lack of documentation indicating the injured worker had signs and symptoms or was diagnosed with osteoarthritis. The injured worker had been utilizing the medication for an extended period of time since at least 11/2013, which exceeds the guidelines recommendations of short term use of four to twelve (4 to 12) weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the quantity of the medication. In addition, the request does not specify a treatment site. Therefore, the request for diclofenac 1% gel apply twice daily is not medically necessary.

Twelve (12) sessions of occupational therapy for the left hand: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 114, 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 injured worker complained of pain, which affected his left wrist and hand. The Chronic Pain Guidelines indicate that passive therapy, those treatment modalities that do not require energy expenditure on the part of the patient, can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation, and swelling to improve the rate of healing soft tissue injuries. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and range of motion. The guidelines allow for fading of the treatment frequency plus active self-directed home physical medicine. The guidelines note that for neuralgia and myalgia eight to ten (8 to 10) visits of physical therapy are recommended. There is a lack of documentation indicating the efficacy of the injured worker's prior course of therapy. The provider failed to document a complete physical examination demonstrating the injured worker had decreased functional ability, decreased range of motion, and decrease strength and flexibility. Additionally, the injured worker has utilized twelve (12) sessions of occupational therapy, as such, the request for the additional twelve (12) sessions would not be medically necessary. The additional twelve (12) sessions exceeds the guidelines recommendations. Therefore, the request is not medically necessary.