MAXIMUS Federal Services

Case Number:	CM14-0153209		
Date Assigned:	09/23/2014	Date of Injury:	04/28/2014
Decision Date:	11/18/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/19/2014

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 California. 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 24-year-old female who reported an injury on 04/28/2014 when, while at her work, she was reaching over to grab a box above her and she felt a cracking to the middle finger. The injured worker complained of middle finger pain and right wrist pain. The diagnoses included contusion to the right wrist, right wrist sprain/strain, and contusion to the metacarpal joint right 3rd finger. Diagnostics included an MRI of the right wrist and an x-ray of the 3rd digit. Past treatments included medication, physical therapy to the right wrist, and wrist support. Medications included Anaprox, Tylenol #3, and Prilosec. The injured worker rated her right wrist pain at 8/10 using the VAS. The examination dated 07/11/2014 of the right wrist revealed no edema, no bruising, no atrophy, no discoloration, no scars, no abrasions, and no lacerations. The range of motion was flexion at 30 degrees, extension at 30 degrees, radial deviation at 10 degrees, and ulnar deviation at 10 degrees. Palpation of the dorsal carpals, extensor tendons, palmar carpals, flexor tendons, snuff box, and hypothenar pad were normal bilaterally. The Tinel's was positive to the right wrist. Strength was 4/5 with flexion and extension. The range of motion to the right 3rd digit was flexion of 90 degrees and extension of 0 degrees. The treatment plan included diclofenac/lidocaine cream and Keratek. The Request for Authorization dated 09/23/2014 was submitted with the documentation. The rationale for the request was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac/Lidocaine Cream 3%/5% 180 g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: The California MTUS Guidelines state that transdermal components compounds are largely experimental in the use of a few randomized trials largely experimental in use with few randomized control trials and are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines state that diclofenac is indicated for the relief of osteoarthritis pain for the joints that include the ankle, elbow, foot, hand, knee, and wrist, and that lidocaine is indicated for neuropathic pain. It is recommended for localized peripheral pain after there has been evidence of a first trial of first line therapy. The guidelines do not recommend diclofenac or lidocaine cream for uses other than neuropathic or osteoarthritis pain. However, the injured worker does not have a diagnosis of osteoarthritis or neuropathic pain. Additionally, the request did not indicate the frequency. As such, the request is not medically necessary.

Kera-Tek analgesic gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The clinical notes were not evident that the injured worker had a diagnosis or had neuropathic pain. The guidelines do not indicate the use of topical analgesics. Additionally, the clinical notes were not evident that the injured worker had a failed trial of antidepressants and anticonvulsants. The request did not indicate the location site at which the cream was intended for or the frequency of the medication. As such, the request is not medically necessary.