

<b>Case Number:</b>	CM14-0181755		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	03/27/2014
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 36 year old male who had a work injury dated 3/27/14. The diagnoses include left thumb laceration and left hand sprain/strain specifically the index, middle and ring fingers. Under consideration are requests for Interferential Unit with conductive gloves; unknown prescription of Lidoderm patch for the left thumb; and one prescription of Neurontin 600 mg #60. The patient complains of left thumb weakness with inability to completely doped fist as left thumb is unable to flex with presence of numbness and tingling to left thumb dorsal aspect with decrease in grip strength. He has 6-8 pain level which is constant and described as aching, sore and with weakness. Inspection of the left hand/wrist reveals a well-healed surgical scar consistent with surgery. Hyperhidrosis is also noted. The patient is unable to make completely closed fist with three- to four-inches lack of one inch approximation of the thumb to the third fingertip, a one-inch lack of approximation of the thumb to the fourth and fifth digits. There is also a decrease in sensation of the left thumb and C6 dermatomal distribution in the wrist and arm. The range of motion of the wrist is measured as follows; flexion is 40 degrees, extension is 40 degrees, radial deviation is 10 degrees and ulnar deviation is 15 degrees. There is grade 4/5 muscle weakness noted in passive range of motion of flexion. The Jamar grip strength is decreased on the left hand compared to the right hand.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential Unit with Conductive Gloves: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, and Hand (Acute & Chronic), Interferential Current Stimulation (ICS)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** Interferential unit with conductive gloves is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that in regards to interferential therapy there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain those criteria are met, then a one-month trial may be appropriate to permit the physician and physical therapy provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. The documentation indicates that this is being ordered for a hand injury for which this treatment has not been evaluated for. Additionally, the guidelines recommend a one month trial prior to dispensing this unit to a patient permanently for home use. The request for interferential unit with conductive gloves is not medically necessary.

**Unknown prescription of Lidoderm patch for the left thumb:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch) Page(s): 56.

**Decision rationale:** Unknown prescription of Lidoderm patch for the left thumb is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Lidoderm is the brand name for a Lidocaine patch. Topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an anti-epilepsy drugs such as Gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The documentation does not indicate failure of first line therapy. The documentation does not describe neuropathic pain. The patient has numbness on examination which is different from neuropathic pain. The request as written indicates no quantity or strength. Unknown prescription of Lidoderm patch for the left thumb is not medically necessary.

**One prescription of Neurontin 600 mg # 60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gabarone, generic available).

**Decision rationale:** One prescription of Neurontin 600 mg #60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The documentation does not describe neuropathic pain. The patient has numbness on examination which is different from neuropathic pain. The request for one prescription of Neurontin 600 mg #60 is not medically necessary.