

Case Number:	CM14-0042485		
Date Assigned:	06/30/2014	Date of Injury:	12/11/2011
Decision Date:	08/18/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	04/08/2014

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 Interventional Spine, 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 patient is a 40-year-old female with date of injury of 12/11/11. The listed diagnoses per [REDACTED] are right wrist tendinitis, right upper extremity repetitive injury, right upper extremity tendinopathy with myofascial pain, left wrist tendinitis, and chronic upper extremity pain. According to the medical reports, the patient complains of right wrist, forearm, elbow, left wrist, and arm pain. The patient describes the symptoms as achy in quality and rates them at 7/10. The patient has experienced the symptoms for years. The patient had physical therapy and reports relieved from treatment. She takes Motrin for pain. The physical examination shows there is tenderness upon palpation of the bilateral wrist and left upper extremity. Muscle girth is symmetric in all limbs. Peripheral pulses are 2+ bilaterally with normal capillary filling. There is full and painless range of motion in all limbs without instability. Bilateral wrist range of motion was restricted by pain in all directions. There is tenderness upon palpation of the bilateral wrists, forearm, and right arm. Muscle stretch reflexes are 1 and symmetric bilaterally in all limbs. Hoffmann's signs are absent bilaterally. Muscle strength is 5/5 in all limbs. Sensation is intact to light touch, pinprick, proprioception, and vibration in all limbs.

IMR ISSUES, DECISIONS AND RATIONALES

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

NSAID Cream for the bilateral hands: Overturned

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical analgesics are recommended as an option primarily for neuropathic pain while trials of antidepressant and anticonvulsants have failed. It is largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical NSAIDs are indicated for patients with osteoarthritis and tendinitis particularly that of the knee and elbow and other joints that are amenable to topical treatment. It is recommended for short-term use between 4 to 12 weeks. The records show that the patient has not used an NSAID cream in the past and the treater documents on 2/19/14 that the patient has failed oral NSAIDs and would like to try NSAID cream for her bilateral wrists. In this case, the patient does present with tendinitis and the requested NSAID use is reasonable. As such, the request is medically necessary.

Functional Restoration Consultation with HELP Program:

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-33, 49.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines support functional restoration program given that the patient must meet specific criteria. To determine the patient's candidacy, a full evaluation is appropriate to obtain. Given the patient's chronic and persistent pain, a functional restoration program consultation is reasonable and is consistent with the MTUS Guidelines. As such, the request is medically necessary.