

Case Number:	CM14-0045933		
Date Assigned:	08/06/2014	Date of Injury:	12/09/2013
Decision Date:	09/11/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/14/2014

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 Orthopedic Surgery 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 claimant is a 42-year-old gentleman injured in a work-related accident on December 9, 2013. The records provided for review indicate multiple orthopedic injuries, including a left distal radial fracture, left shoulder impingement, left hip strain, and left knee and ankle pain. An orthopedic assessment dated April 4, 2014, included plain film radiographs of the left wrist, demonstrating a well healed-fracture. The office note states that the claimant has continued difficulty with multiple orthopedic injuries, despite recent conservative care that has included medication management. It is noted that the claimant has numbness to the left upper extremity digits with 4/5 strength with wrist flexion and extension; diminished strength with elbow flexion and extension, and a left shoulder examination with positive Hawkin's and impingement testing. Grip strength was noted to be weaker with wrist tenderness at the distal ulnar radial joint. The claimant was diagnosed with: a closed fracture of the left distal radius; strains of the left hip, left knee and left ankle; left elbow ulnar neuritis; and underlying stress, anxiety and depression. This request is for: continuation Terocin patches; continuation of LidoPro lotion; continuation of Protonix; a left upper extremity EMG; a left wrist and forearm MRI; a TENS unit; a wrist brace; and 12 additional sessions of physical and chiropractic therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Protonix 20 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 ; Prilosec: GI symptoms & cardiovascular risk, page 68-69 Page(s): 68-69..

Decision rationale: California MTUS Chronic Pain Medical Guidelines would not support the continued use of Protonix. The Chronic Pain Guidelines criteria recommend the use of a proton pump inhibitor like Protonix if the claimant has a risk factor for gastrointestinal event. In this case, the claimant is an otherwise healthy, 41-year-old gentleman with no significant history of gastrointestinal risk factor or documented need for a protective gastrointestinal agent. Absent documentation of gastrointestinal issues, this request would not be established as medically necessary.

Terocin #20: 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 X : Topical Analgesics Page(s): 111-113.

Decision rationale: Based on California MTUS Chronic Pain Medical Treatment Guidelines, Terocin patches would not be indicated. Terocin in topical form is a combination of Methyl Salicylate, Capsaicin, Menthol, and Lidocaine. Under MTUS Chronic Pain Guidelines, the use of an agent is not supported when any one ingredient in the agent is not supported. Lidocaine is typically only recommended for neuropathic pain after evidence of first-line therapy such as tricyclic antidepressants or agents such as Gabapentin or Lyrica have failed. The records in this case do not document first-line treatment for neuropathic pain. Because the use of Lidocaine is not supported, the request for Terocin patch, which contains Lidocaine, is not supported. Therefore, this request is medically not necessary.

LidoPro lotion 4oz: 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 : Topical Analgesics Page(s): 111-113.

Decision rationale: Based on California MTUS Chronic Pain Medical Treatment Guidelines, the use of LidoPro lotion would not be indicated. As noted above, Under the Chronic Pain Guidelines, the use of an agent is not supported when any one ingredient in the agent is not supported. LidoPro contains Lidocaine, which is typically only recommended for neuropathic pain after evidence of first-line therapy such as tricyclic antidepressants or agents such as Gabapentin or Lyrica have failed. The records in this case do not document first-line treatment

for neuropathic pain. Because the use of Lidocaine is not supported, the request for LidoPro lotion, which contains Lidocaine, is not supported. Therefore, this request is medically not necessary.

EMG left upper extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: California MTUS ACOEM Guidelines would not support a left upper extremity electrodiagnostic study in this case. Under ACOEM Guidelines, electrodiagnostic testing is indicated to help identify subtle, focal neurologic dysfunction when neck and/or arm symptoms last greater than three to four weeks. While the reviewed records in this case document weakness, they also reference orthopedic diagnoses of the shoulder, elbow and wrist, including a wrist fracture. The working diagnoses and clinical presentation as conveyed in the reviewed records are not consistent with upper extremity neurologic findings to support the need for electrodiagnostic testing. This request, therefore, would not be established as medically necessary.

MRI of left wrist and forearm: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2013 Updates: forearm/wrist/hand procedure.

Decision rationale: When looking at Official Disability Guideline criteria, wrist MRI scans are recommended for chronic wrist pain with plain film radiographs for suspicion of tumor, Kienbock's disease or tissue trauma. While this individual is noted to be with continued stiffness following a wrist fracture, there is currently no positive physical examination finding that would be indicative of ligamentous or tendinous injury that would support the acute need of imaging at this stage in the claimant's clinical course of care. The request for MRI scan of the left wrist to include the forearm would not be supported. Under guidelines criteria, wrist MRI scans are recommended for chronic wrist pain as a follow up to suspicious plain film radiographs to rule out tumor, Kienbock's disease or tissue trauma. For that reason, this request is not medically necessary under guidelines criteria.

TENS unit: 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 ; Page(s): 114, 116.

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines would not support the use of a TENS device. Under Chronic Pain Guidelines, TENS devices are supported for a one-month, home-based trial as an adjunct to a program of evidence-based functional restoration. In this case, the records do not reflect that the claimant is engaged in a Functional Restoration Program, nor do they specify the length of recommended treatment with the TENS device. As an isolated intervention and in the absence of a specific duration of use, the request for a TENS unit would not be supported as medically necessary.

Soft and rigid brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2013 Updates: forearm, wrist, hand procedure Splints.

Decision rationale: California MTUS ACOEM Guidelines and the Official Disability Guidelines do not recommend the use of a splint to the wrist. The ODG Guidelines recommend wrist splinting for treatment of a displaced fracture and in the post-operative setting. Splinting is not typically recommended by the ACOEM Guidelines for subacute treatment of hand or wrist complaints. This claimant's imaging demonstrates a well-healed fracture to the wrist. Additionally, the documentation does not provided any rationale as to why the claimant could not advance to a Home Exercise Program to build strength and mobility. Given these factors, this request would not be established as medically necessary.

Physical therapy and/or Chiropractic times twelve: 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 ; Physical Medicine, page 98-99. Manual therapy Page(s): 98-99.

Decision rationale: California MTUS Chronic Pain Guidelines would not support 12 sessions of physical therapy and chiropractic care. In the presence of chronic wrist, forearm and hand pain, Chronic Pain Guidelines do not recommended the use of manual therapy. Under Physical Medicine, in cases of acute exacerbation, nine to 10 visits over an eight-week period would be permissible. In this case, the request is not supported as medically necessary because reviewed

records contain no documentation of acute exacerbation and the requested 12 sessions exceed the Chronic Pain maximum. Therefore, this request is medically not necessary.