

Case Number:	CM14-0078166		
Date Assigned:	07/18/2014	Date of Injury:	08/10/2007
Decision Date:	08/29/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	05/29/2014

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 and Washington. 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 41-year-old female who reported an injury on 08/10/2007. The mechanism of injury was not submitted in the report. The injured worker has diagnoses of disorder of bursae and tendons in shoulder region, unspecified, and other affections of shoulder region, not elsewhere classified. The injured worker has had home exercise program, previous hand injections, and medication therapy. An NCV(nerve conduction velocity) on the injured worker's ulnar and median sensory was done on 04/22/2014. The electro diagnostic testing revealed that there was no evidence of radiculopathy or median, ulnar, radial, mononeuropathy in either side. The injured worker underwent left hand surgery in 02/21/2006. The injured worker complained of left shoulder and wrist pain with some numbness in the left hand. There were no measurable pain levels documented in the submitted report. Physical examination dated 04/17/2014 revealed that the injured worker was tender to palpation on posterior and lateral shoulder left side. The injured worker had a forward flexion of 4+/5, abduction of 5-/5, external rotation of 5-/5, and internal rotation of 5-/5, all with pain. The injured worker demonstrated mild pain with empty can test. Neer's impingement sign was negative. Hawkins impingement, the labral test, Speed's, and Obrien's tests were positive. The submitted reports lacked any evidence of range of motion or motor strength on the injured worker's wrists. The injured worker's medications include Naprosyn 550 mg 1 tablet 2 times a day, Omeprazole 20 mg 1 tablet 1 to 2 times a day, Neurontin 500 mg 3 times a day, and Terocin patches. The treatment plan is for the injured worker to have a follow-up appointment with the provider for a possible repeat left hand injection and to continue the Terocin patches. The rationale and request for authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Followup with [REDACTED] for possible injection, left hand: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, Office Visits.

Decision rationale: The request for Follow-up with [REDACTED] for possible injection, left hand is not medically necessary. ODG guidelines recommend office visits as they are to be determined medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. The submitted documentation did not include information regarding the specific current reduction of pain or functional gains after prior hand injections. The only documentation submitted in the progress note dated 06/05/2014 was that the injured worker stated that "The last injection helped," which does not warrant the necessary information for a medical determination of necessity for a repeat injection of the hand. Furthermore, there was insufficient information to determine if an appointment for a repeat injection is even medically necessary. Also, the submitted request does not specify what type of injection is being requested. As such, the request for a follow-up with [REDACTED] for possible injection, left hand is not medically necessary.

Terocin patch 1/10: 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 Lidocaine (Terocin) Page(s): 112.

Decision rationale: The request for Terocin patch 1/10 is not medically necessary. The injured worker complained of left shoulder and wrist pain with some numbness in the left hand. There were no measurable pain levels documented in the submitted report. Terocin patches consists of Lidocaine 4% and Menthol 4%. CA MTUS states Lidocaine in a transdermal application is recommended for neuropathic pain and recommended for localized peripheral pain after there

has been evidence of a trial of first-line therapy such as a tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica. No other commercially approved topical formulations of lidocaine whether creams, lotions or gels are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritic. In February 2007, the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Only FDA-approved products are currently recommended. The submitted report lacked documentation showing that the injured worker had a diagnosis of neuropathic pain. The guidelines also state that Lidocaine is recommended for localized peripheral pain however, there was no documentation submitted in the report that the injured worker had such pain. Furthermore, there was no evidence noted in the submitted reports showing the outcome of The use of first line therapies such as tricyclic or snri antidepressants or AEDs, such as Gabapentin or Lyrica. Reports show that the injured worker had been taking Gabapentin (Neurontin), but the efficacy of the medication was not provided. Also, the efficacy of the requested medication was not documented to support continuation of the requested medication. The submitted request also did not specify the duration or frequency of the medication. As such, the request for Terocin patch 1/10 is not medically necessary.