

Case Number:	CM13-0065733		
Date Assigned:	01/03/2014	Date of Injury:	05/05/2010
Decision Date:	03/26/2015	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	12/13/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New York
Certification(s)/Specialty: Internal Medicine

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 42 year old female who was injured on 05/05/2010. The mechanism of injury is unknown. Her diagnoses include right shoulder pain, right elbow, and right wrist pain. She is status post right elbow ECRB debridement with extensor tendinitis and possible TFCC tear versus chronic ECU tendinitis .Prior treatment history has included medications, physical therapy and injections. Diagnostic studies reviewed include MRI of the right shoulder w/o contrast dated 07/30/2013 revealing: 1) Mild to moderate right AC joint osteoarthritis, with small joint effusion. 2) Attenuated rotator cuff tendon, with multiple tears including 25% of the distal supraspinatus and 30% of the subscapularis. 3) Degenerative changes are identified in the superior and inferior glenoid labrum, with mild tendinopathy in the distal biceps tendon (proximal to the bicipital groove).Progress noted dated 11/06/2013 documented the patient is not responding to treatment. She feels she may be worse since she is working. Visual analog pain score 8/10 at worst. She did not get much relief from the injection. She is doing her exercises. Objective findings reveal shoulder exam range of motion right side flexion 160, external rotation 60 degrees, internal rotation L5. Left side flexion 160 degrees, external rotation 70 degrees, internal rotation T12. Rotator cuff exam reveals: supraspinatus affected side bilaterally 5 and tender. Normal side left bilaterally 5. Neer's test for impingement is positive as well as Hawkin's test. Speed's test for bicipital pain is positive. Sensation is intact. Progress note 12/22/2013 documented the patient to have complaints of wrist pain that has been going on since the cast was removed after her tennis elbow debridement 14 months ago. She is wearing a splint on her wrist today. She has not been back to see me since October of 2012 despite the complaints of

dorsal wrist pain since that time. She states the elbow is good. She states" it is so much better than before the surgery". Overall the patient is not improving form the wrist issue but elbow is better. Objective findings on exam included tenderness to palpation over forearm tendon crossover, over TFCC, over dorsal aspect of hand despite complaints of pain and over the dorsal hand proximal to MCP joints. Elbow range of motion 5-145 flexion with full pronation and supination. Wrist range of motion within normal limits but grimacing. Sensation is intact. The treating provider has requested Terocin Lotion 120ml, MRI with contrast of the right wrist, and a pre-op arthrogram of the right wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

TEROCIN LOTION 120ML: 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: According to the references, Terocin lotion contains lidocaine. The CA MTUS state only Lidocaine in the formulation of Lidoderm patch may be considered for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). The guidelines state no other commercially approved topical formulations of lidocaine are indicated for neuropathic pain. Only FDA-approved products are currently recommended. Topically applied lidocaine is not recommended for non-neuropathic pain. In addition, the medical records document the patient has been supplied with this product for a prolonged period, however, there is no demonstrated benefit with use. The medical records do not establish this topical lotion is appropriate and medically necessary for this patient. The request of Terocin lotion is not medically necessary.

Pre-Op MRI W/Contrast Right Wrist Only: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Imaging

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, MRI's (magnetic resonance imaging)

Decision rationale: Per the reviewed guidelines, MRI's (magnetic resonance imaging) - Recommended as indicated below: Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required, Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required, Acute hand or

wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury), Chronic wrist pain, plain films normal, suspect soft tissue tumor, Chronic wrist pain, plain film normal or equivocal, suspect Kienbock's disease. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The medical records support the request for MRI of the wrist. The patient's wrist complaint is chronic (present x 14 months) and clinical findings suggest that a potential TFCC tear is a possibility. The MRI is needed to rule out TFCC tear. Medical necessity for the MRI has been established. The MRI is medically necessary and indicated.

Pre-Op Right Wrist Arthrogram: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Indications for Imaging

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, Arthrography, MRI's (magnetic resonance imaging)

Decision rationale: The medical records do not support the request for an arthrogram of the wrist. The MRI requested is sufficient for evaluation for possible TFCC tear or any other soft tissue abnormality. There is no specific indication for a pro-op arthrogram in addition to a MRI. Medical necessity for the requested study has not been established. The requested arthrogram is not medically necessary.