

Case Number:	CM14-0131825		
Date Assigned:	08/20/2014	Date of Injury:	05/09/2007
Decision Date:	09/24/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/18/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas & Oklahoma. 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 55 year old male who reported injury on 05/09/2007. The mechanism of injury was not provided. Diagnoses included status post right wrist ganglion removal, 11/26/2012. Prior treatments included 18 sessions of therapy; however, the type of therapy was not indicated. The progress note dated 04/21/2014 noted the injured worker complained of right hand pain rated 5-6/10 radiating to his arm. He also reported a mass that occasionally grew at the incision site. The physical exam revealed a well healed incision. Range of motion noted extension 45 and flexion 25, and grip strength 14-14-12 to the right and 15-13-14 on the left. Medications were not documented. The treatment plan included recommendations for a follow-up appointment and muscle testing of the hand. The Request for Authorization form and rationale for the requests 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:

TENS (Transcutaneous Electrical Nerve Stimulation)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 TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-117.

Decision rationale: The injured worker had right hand pain status post ganglion cyst removal. The California MTUS guidelines recommend the use of a TENS unit as an adjunct to ongoing treatment modalities, within a functional restoration approach, for chronic pain when there is evidence that other appropriate pain modalities have been tried (including medication) and failed. Furthermore, the guidelines state a one-month trial period of the TENS unit should be documented to include how often the unit was used, as well as, outcomes in terms of pain relief and function. Rental is preferred over purchase during this trial period. There is no documentation of failed or ongoing pain treatment modalities. There is no documentation indicating the injured worker has completed a one month trial with documentation indicating how often the unit was used as well as detailing the injured worker's pain relief and increase in function with the unit. The location intended for use is not specified to determine medical necessity. Due to the lack of documentation of failed or ongoing pain treatment modalities, the exclusion of the location intended for use, and rental of the TENS unit being preferred for the trial period, the purchase of this equipment would be unsupported and excessive at this time. Therefore, the request is not medically necessary.

Flurbiprofen 20% Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The injured worker had right hand pain status post ganglion cyst removal. The California MTUS guidelines state topical NSAIDs are recommended for short term treatment of osteoarthritis of the knee and elbow or other joints that are amenable to topical treatment. There is no indication of osteoarthritis to a joint amenable to topical treatment. The location intended for treatment as well as the frequency at which the medication is to be used were not included to determine medical necessity. Given the lack of evidence of osteoarthritis, and the exclusion of frequency and location intended for use, the use of Flurbiprofen cream is not supported at this time. As such, the request is not medically necessary.