

Case Number:	CM14-0162504		
Date Assigned:	10/07/2014	Date of Injury:	02/05/2010
Decision Date:	11/07/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	10/02/2014

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 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 injured worker is a 52-year-old female who reported an injury on 02/05/2010. The mechanism of injury occurred when a door closed on her right index finger. Diagnoses included right index finger crushing injury with residual numbness, stiffness, and mallet finger deformity. Past treatments included physical therapy, right hand finger splint, and medications. Diagnostic studies included unofficial x-rays of the right hand on 09/09/2014, which were reportedly unremarkable. Surgical history included partial excision of accessory muscle and exploration, carpal tunnel release of the right wrist and palm, tightening of the extensor tendon and pinning of the distal interphalangeal joint of the right index finger on 06/09/2010; flexor tendon tenolysis, synovectomy and exploration of the carpal canal on 03/18/2011; and right long finger trigger release and tenosynovectomy on 09/17/2013. The clinical note dated 09/08/2014 indicated the injured worker complained of pain in the right hand, index and long fingers, with pain radiating to the upper arm. She also complained of weakness in the fingers, swelling at the palm, numbness and tingling. The physical exam revealed positive Phalen's test to the right hand, and decreased range of motion of the right fingers. Current medications included trazodone, Wellbutrin, and tramadol. The treatment plan included a Functional Capacity Evaluation, interferential current stimulator, and Gaba-Keto-Lido cream. The rationale for the Functional Capacity Evaluation was not provided. The rationale for the interferential current stimulator and compounded cream was pain control. The Request for Authorization form was completed on 09/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Evaluation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation (FCE)

Decision rationale: The request for a Functional Capacity Evaluation is not medically necessary. The California MTUS Guidelines indicate that it may be necessary to obtain a more precise delineation of patient capabilities than is available through routine physical exam. Under some circumstances, this can best be done by ordering a Functional Capacity Evaluation of the patient. The Official Disability Guidelines go on to state that a Functional Capacity Evaluation is recommended prior to admission to a work hardening program, but is not recommended for routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. The clinical note dated 09/08/2014 indicated the injured worker complained of pain in the right hand, index and long finger. She also complained of weakness in the fingers, swelling of the palm, and numbness and tingling. The rationale for the treatment plan was not provided. There is a lack of clinical documentation to indicate the injured worker had been approved for a work hardening program. The guidelines do not recommend a Functional Capacity Evaluation if the sole purpose is to determine a worker's effort or compliance. Therefore, the treatment plan cannot be supported at this time, and the request for a Functional Capacity Evaluation is not medically necessary.

Interferential Current Stimulator, 2 Channel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 118-120.

Decision rationale: The request for interferential current stimulator, 2 channel, is not medically necessary. The California MTUS Guidelines indicate that interferential current stimulation is not recommended as an isolated intervention. The guidelines indicate that the criteria for the use of interferential current stimulation includes documented pain that is ineffectively controlled due to diminished effectiveness of medications, pain that is ineffectively controlled with medications due to side effects, history of substance abuse, or unresponsive to conservative measures. If criteria are met, then a one month trial may be appropriate to permit the provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. The clinical note dated 09/08/2014 indicated the injured worker complained of pain in the right hand, index and long finger. She also complained of weakness in the fingers, swelling of the palm, and numbness and tingling. There is a lack of documentation of a prior 1 month trial of the interferential current stimulator,

with documented quantified pain relief, functional improvement, and evidence of medication reduction. There is also a lack of documentation that the injured worker's pain was not controlled with conservative treatments. Therefore, the treatment plan cannot be supported at this time, and the request for interferential current stimulator, 2 channel, is not medically necessary.

Gaba-Keto-Lido 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): 111-113.

Decision rationale: The request for Gaba-Keto-Lido cream is not medically necessary. The California MTUS Guidelines indicate that topical analgesics are largely experimental with few randomized controlled trials to determine efficacy or safety. Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical Gabapentin is not recommended, and there is no peer reviewed literature to support its use. Topical NSAIDs are indicated for osteoarthritis and tendonitis, in particular, that of the knee and elbow or other joints that amenable to topical treatment. Topical lidocaine in the formulation of a dermal patch Lidoderm has been designated for orphan status with FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. As the requested compound contains Gabapentin which is not recommended, and lidocaine in a formulation which is not recommended, the treatment plan cannot be supported at this time. Additionally, the request does not indicate the quantity, frequency, or specific location for using the cream. Therefore, the request for Gaba-Keto-Lido cream is not medically necessary.