

Case Number:	CM14-0093334		
Date Assigned:	07/25/2014	Date of Injury:	05/19/2013
Decision Date:	09/18/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/19/2014

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, has a subspecialty in Interventional Spine 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 patient is a 26 years old female with an injury date on 05/19/2013. Based on the 05/20/2014 progress report provided by Dr. [REDACTED], the diagnosis is: 1. Pain in joint forearm s/p scapholunate ligament reconstruction. According to this report, the patient complains of status post right wrist pain and starts to notice pain in the left wrist. The patient states that the pain in the bilateral upper extremities is affecting her sleep. The pain is rated as a 9/10. Per treating physician, the "medications are helpful in reducing some pain and improving the patient function." Physical exam reveals tenderness to palpation over the dorsal left wrist on the unlar aspect. Wrist range of motion is limited with pain. There were no other significant findings noted on this report. The utilization review denied the request on 06/04/2014. Dr. [REDACTED] is the requesting provider, and he provided treatment reports from 01/03/2014 to 06/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin: 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: According to the 05/20/2014 report by Dr. [REDACTED] this patient presents with status post right wrist pain and starts to notice pain in the left wrist. The treating physician is requesting Terocin (patch). Terocin patches are a dermal patch with 4% lidocaine, and 4% menthol. Terocin patch was first noted in the 03/12/2014 report. The MTUS guidelines state that Lidoderm patches may be recommended for neuropathic pain when trials of antidepressants and anti-convulsants have failed. Review of the reports do not indicate the patient has neuropathic pain. There is no documentation of the effects of this medication as required per page 60 of MTUS. Given the above the request is not medically necessary.

Relafen 730mg: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Chapter Procedure Summary NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's pain; Anti-inflammatory medications; NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60, 61; 22; 67,68.

Decision rationale: According to the 05/20/2014 report by Dr. [REDACTED] this patient presents with status post right wrist pain and starts to notice pain in the left wrist. The treater is requesting Relafen 730mg. The MTUS Guidelines pages 60 and 61 reveal the following regarding NSAID's, "Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted." Review of reports show no mentions of Relafen and it is unknown exactly when the patient initially started taking this medication. Per report, "medications are helpful in reducing some pain and improving the patient function". Therefore, the requested Relafen appears reasonable and consistent with MTUS guidelines. Given the above the request is medically necessary.

Muscle Testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Forearm, Wrist and Hand Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 262.

Decision rationale: According to the 05/20/2014 report by Dr. [REDACTED] this patient presents with status post right wrist pain and starts to notice pain in the left wrist. The treater is requesting "muscle testing" but the treating physician's report and request for authorization containing the request is not included in the file. The treater does not explain what this muscle test is to entail. If the request was for an EMG, it may be supported by the ACOEM guidelines to differentiate CTS vs. radiculopathy and other conditions. However, "muscle testing" which may be muscle strength testing, is part of a routine physical examination and does not require separate billing. The

treating physician needs to specify the request and unfortunately the report containing the request is missing. Given the above the request is not medically necessary