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| Case Number: | CM13-0006479 | | |
| Date Assigned: | 05/02/2014 | Date of Injury: | 03/05/1999 |
| Decision Date: | 07/08/2014 | UR Denial Date: | 07/17/2013 |
| Priority: | Standard | Application Received: | 08/05/2013 |

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in pain medicine 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 60-year-old female who has submitted a claim for Mood Disorder, Pain in Joint Lower Leg, and Foot Pain, associated with an industrial injury date of March 5, 1999. Medical records from 2010 through 2013 were reviewed, which showed that the patient complained of lower extremity pain. On physical examination, the patient had an antalgic gait and ambulated with a cane. There was tenderness noted over the right heel and midfoot. There was also tenderness noted over the left tarsal tunnel and medial foot/ankle. No bipedal edema was reported. Motor strength was normal. There was left leg swelling with 1+ edema up to the mid-calf. No calf tenderness was noted. Treatment to date has included physical therapy, steroid injections, left partial open plantar fasciotomy, left extensive tarsal tunnel release, meniscal surgery, Game Ready Compression Device, and medications including Voltaren Gel 1% (since January 2012), and Lactaid caplets 2 tabs PO TID before meals (since October 2012). Utilization review from July 17, 2013 denied the request for Voltaren Gel because of absent documentation of medical necessity for long-term application of this topical NSAID; Lactaid because there was no documentation of medical necessity; and continuous cryotherapy and pneumatic compression because guideline criteria were not met.

IMR ISSUES, DECISIONS AND RATIONALES

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

VOLTAREN GEL: Upheld

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

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

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, Voltaren Gel 1% (diclofenac) is indicated for relief of osteoarthritic pain in joints that lend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of spine, hip, or shoulder. In this case, Voltaren Gel was being prescribed since January 2012 (more than 2 years to date). However, there was no documentation of continued functional benefit with this medication. The medical records also failed to provide evidence of osteoarthritis, which may warrant the use of Voltaren Gel. There is no clear indication for continued use of this medication. Therefore, the request for Voltaren Gel is not medically necessary and appropriate.

LACTAID: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Medical Food.

Decision rationale: The Official Disability Guidelines (ODG) states that to be considered, the product must meet the following criteria: (1) the product must be for oral or tube feeding; (2) the product must be labeled for dietary management of a specific medical disorder for which there are distinctive nutritional requirements; and (3) the product must be used under medical supervision. In this case, Lactaid was being prescribed since October 2012 (20 months to date). However, there was no documentation of continued therapeutic benefits. The medical records also failed to provide evidence of a specific disorder with distinctive nutritional requirements, such as lactose intolerance, which may warrant intake of Lactaid. There is no clear indication for continued use of this product. Therefore, the request for Lactaid is not medically necessary and appropriate.

CONTINUOUS CRYOTHERAPY AND PNEUMATIC COMPRESSION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Game Ready Accelerated Recovery System.

Decision rationale: The Official Disability Guidelines (ODG) states that Game Ready accelerated recovery system is recommended as an option after surgery but not for non-surgical treatment. The Game Ready system combines continuous-flow cryotherapy with the use of vasocompression. While there are studies on continuous-flow cryotherapy, there are no published high quality studies on the Game Ready device or any other combined system. In this case, the patient was documented to be using a Game Ready system. However, functional benefits were not documented. Furthermore, there was no evidence that the patient was in a post-operative state. There is no clear indication for continued use of this device. Therefore, the request for continuous cryotherapy and pneumatic compression is not medically necessary and appropriate.