MAXIMUS Federal Services

Case Number:	CM13-0016689		
Date Assigned:	11/06/2013	Date of Injury:	07/19/2012
Decision Date:	02/20/2014	UR Denial Date:	08/14/2013
Priority:	Standard	Application Received:	08/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified Physical Medicine and 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 physician 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 46-year-old injured worker who reported an injury on 07/19/2012 after a physical altercation that caused injury to the head, face, and left knee. The patient's treatment history included medication management, physical therapy, acupuncture, and psychiatric support. The patient's most recent clinical findings included tenderness to palpation and spasming of the bilateral paraspinal musculature from the C2 to the C5 levels, bilateral suboccipital muscles, and bilateral upper shoulder muscles. The patient had a positive axial compression test bilaterally and positive distraction test bilaterally. The patient had decreased biceps reflexes and triceps reflexes. Evaluation of the shoulders revealed spasming and tenderness to the bilateral upper shoulder muscles and bilateral rotator cuff muscles with a positive Codman's test on the right and a positive Speed's test bilaterally. The physical examination of the knee revealed limited range of motion, a positive valgus test and varus test on the left and a positive McMurray's test on the left. The patient's diagnoses included a tear of the medial meniscus of the left knee, lateral collateral ligament sprain of the knee, central disc herniation with myelopathy, partial tear of the rotator cuff tear, bursitis and tendonitis at the bilateral shoulders and tension headaches. The patient's treatment plan included an MRI of the head, an MRI of the knee, the use of a soft knee brace, and initiation of topical medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

3D MRI of the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 1021-1022.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, MRI.

Decision rationale: The Official Disability Guidelines do not support repeat imaging unless there is a significant change in presentation or the suspicion of a change in pathology. The clinical documentation submitted for review does not provide any evidence that the patient has had a significant change in pathology or clinical presentation to support the need for an additional MRI. The request for a3D MRI of the left knee is not medically necessary and appropriate.

3D MRI Brain: 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) Head Chapter, MRI.

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

Decision rationale: The Official Disability Guidelines do not recommend MRIs unless there is a need to determine neurological deficits not explained by a CT. The clinical documentation submitted for review does provide evidence that the patient previously underwent an imaging study of the brain. Clinical documentation submitted for review does not provide any evidence of neurological deficits related to previous head trauma. The clinical documentation does not provide evidence that the patient had an extended duration of loss of consciousness or a significant change in clinical presentation that would support the need for an additional imaging study. The request for a 3D MRI of the brain is not medically necessary and appropriate.

FlurFlex 180gm: Upheld

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

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

Decision rationale: California Medical Treatment Utilization Schedule does not recommend the use of topical nonsteroidal anti-inflammatory drugs such as Flurbiprofen unless the patient is unable to tolerate oral formulations or if oral nonsteroidal anti-inflammatory drugs are contraindicated for the patient. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to oral nonsteroidal anti-inflammatory drugs. The request for FluriFlex 180 gm is not medically necessary and appropriate.

TGHot 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Topical Analgesics, and Skolnick P (1999) Antidepress.

Decision rationale: The clinical documentation submitted for review does provide evidence that this medication contains tramadol, gabapentin, menthol, camphor, and Capsaicin. The California Medical Treatment Utilization Schedule does not recommend the use of Capsaicin in a topical formulation. Additionally, the requested medication contains a formulation of Capsaicin that is greater than the recommended 0.025%. Also, the California Medical Treatment Utilization Schedule does not recommend the use of gabapentin as a topical agent as there is no scientific evidence to support the efficacy of this medication. Peer reviewed literature does not recommend the use of opioids in topical formulations as there is no scientific evidence to support the efficacy of these medications. The California Medical Treatment Utilization Schedule does not recommend the use of a compounded agent that contains 1 or more drug classes that are not supported by guideline recommendations. The request for TGHot 180 gm is not medically necessary and appropriate.

Ibuprofen 600mg, quantity 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 60 and pg. 67..

Decision rationale: The California Medical Treatment Utilization Schedule recommends medications used in the treatment of chronic pain be supported by a quantitative assessment of pain relief and documentation of functional benefit. The clinical documentation submitted for review does not provide any evidence of pain relief or functional benefit as it is related to this medication. Therefore, continued use would not be indicated. The request for Ibuprofen 600 mg quantity 120 is not medically necessary and appropriate.