

Case Number:	CM13-0045436		
Date Assigned:	12/27/2013	Date of Injury:	02/17/2010
Decision Date:	02/28/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/12/2013

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 in 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 66-year-old male who reported an injury on 02/17/2010 after he lifted an air conditioning unit that caused injury to his low back and left knee. The patient underwent a right knee partial medial and lateral meniscectomy and chondroplasty in 01/2011. The patient received postsurgical treatment to include medications and physical therapy. The patient's chronic knee pain was managed with tramadol. The patient was regularly monitored with urine drug screens. The patient's physical findings included crepitation with painful range of motion and medial joint line tenderness without evidence of effusion. The patient's diagnoses included status post right knee arthroscopy and right knee degenerative joint disease. The patient's treatment plan included continued medications, the addition of a ketoprofen/gabapentin cream and the use of an interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% Gabapentin 6%, 240gm, QTY 1 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

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

Decision rationale: The requested ketoprofen 20% gabapentin 6% at 240gm (Quantity: 1.00) with 3 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the use of ketoprofen as a topical agent as it is not FDA approved in this formulation. Additionally, the California Medical Treatment Utilization Schedule does not recommend the use of topical gabapentin, as it is not supported by adequate scientific evidence to support the efficacy and safety. The California Medical Treatment Utilization Schedule states that any compounded medication that contains at least 1 drug or drug class that is not recommended is not supported by guideline recommendations. Therefore, the use of ketoprofen 20%, gabapentin 6% at 240gm (Quantity: 1.00) with 3 refills is not medically necessary or appropriate.

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Stimulation Unit Page(s): 118.

Decision rationale: The requested interferential unit was not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is using an interferential unit. It was noted that the patient receive adequate relief of symptoms from that unit. The California Medical Treatment Utilization Schedule does recommend the continued use of an interferential unit in the management of a patient's chronic pain. The clinical documentation submitted for review, however, fails to provide evidence that the current unit is no longer functioning or providing adequate relief and that a replacement unit is required. Therefore, the need for an interferential unit is not clearly established. As such, the requested interferential unit is not medically necessary or appropriate.

Cervical Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: The requested cervical epidural steroid injection is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence that the patient's pain is radicular in nature. There was no evaluation of the patient's cervical spine. The California Medical Treatment Utilization Schedule recommends epidural steroid injections for patients who have documented clinical findings of radiculopathy supported by an imaging study that have been recalcitrant to active therapy. The clinical documentation submitted for review does not provide an imaging study of the cervical spine, nor are there any documented clinical findings of radiculopathy. Therefore, the need for cervical epidural steroid

injections is not indicated. As such, the requested cervical epidural steroid injection is not medically necessary or appropriate.

MRI of lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines (2nd edition) page 303. Official Disability Guidelines (ODG) Treatment Index, 7th edition (Web) current year, Low Back, MRI

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The requested MRI of the lumbar spine is not medically necessary or appropriate. The clinical documentation submitted for review does not provide an assessment of the lumbar spine to support the need for an imaging study. The American College of Occupational and Environmental Medicine recommends the use of an MRI to clarify neurological deficits that are determined during the physical evaluation. The clinical documentation submitted for review does not provide any evidence that the patient has any neurological deficits that would require an imaging study. As such, the requested MRI of the lumbar spine is not medically necessary or appropriate.

Acupuncture: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested acupuncture is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of acupuncture as an adjunct therapy for patients with chronic pain. The clinical documentation submitted for review does not provide any evidence that the patient is currently participating in active therapy that would benefit from an adjunct therapy, such as acupuncture. Additionally, the frequency and duration was not clearly provided within the submitted request. Therefore, the need for this type of treatment cannot be determined. As such, the requested decision for acupuncture is not medically necessary or appropriate.

Urinalysis toxicology: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 7th Edition (Web) 2013, Urine Drug Testing

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: The requested urinalysis toxicology is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence that the patient is taking a controlled substance that would require a urine drug screen. The California Medical Treatment Utilization Schedule recommends a urine drug screen when the patient is suspected of using illicit drugs or there is suspicion of aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient is suspected of using illicit drugs or that there is a need to monitor the patient for aberrant behavior. The patient's most recent urine toxicology was collected on 10/09/2013, which was positive for tramadol. The clinical documentation does indicate that the patient is taking tramadol. The Official Disability Guidelines recommend that patients who are not at risk for aberrant behavior be monitored for medication compliance on a yearly basis. Therefore, additional monitoring would not be indicated. As such, the requested urinalysis toxicology is not medically necessary or appropriate.