

Case Number:	CM13-0063967		
Date Assigned:	01/03/2014	Date of Injury:	11/01/2006
Decision Date:	04/22/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/06/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 47-year-old female who reported an injury on 11/01/2006. The patient was reportedly injured when she was struck by a forklift truck. The patient is currently diagnosed with lumbar disc protrusion, lumbar spinal stenosis, lumbar radiculopathy, and left knee internal derangement. The patient was seen by [REDACTED] on 10/07/2013. The patient reported 5/10 lower back pain with radiation to the left lower extremity, as well as 7/10 left knee pain. Physical examination revealed diminished lumbar range of motion, positive straight leg raise on the left, tenderness at the lumbar spine, diminished left knee range of motion, and tenderness to the medial and lateral joint line. Treatment recommendations at that time included prescriptions for a Terocin compounded cream, flurbiprofen compounded cream, and gabacyclotram compounded cream, Genicin capsules, Somnicin capsules, extracorporeal shockwave lithotripsy, a left knee brace, and a prescription for Terocin pain patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

URINE DRUG SCREEN: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77, 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing

Decision rationale: California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. As per the documentation submitted, the patient's injury was greater than 7 years ago to date. There is no indication of non-compliance or misuse of medication. There is also no indication that this patient falls under a high risk category that would require frequent monitoring. Based on the clinical information received, the request is non-certified.

TEROCIN PAIN PATCH BOX (10 PATCHES): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. As per the documentation submitted, there is no indication of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. The patient does not meet criteria for the requested medication. As such, the request is non-certified.

SHOCK WAVE THERAPY: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Extracorporeal shock wave therapy (ESWT)

Decision rationale: California MTUS/ACOEM Practice Guidelines state physical modalities have no scientifically-proven efficacy in treating acute knee symptoms. Extracorporeal shockwave therapy is currently under study for patellar tendinopathy and long bone hypertrophic nonunions. The patient does not appear to meet criteria for the requested service. Therefore, the request is non-certified.

30 SOMNICIN: Upheld

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

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

Decision rationale: Official Disability Guidelines state medical food is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. As per the documentation submitted, there is no documentation of a nutritional deficiency. There is also no documentation of chronic insomnia, anxiety, or muscle tension. Based on the clinical information received, the medical necessity has not been established. As such, the request is non-certified.

180 GMS OF GABACYCLOTRAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Gabapentin is not recommended. Cyclobenzaprine is also not recommended. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

180GMS OF FLURBI (NAP) CREAM-LA: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA-approved topical (NSAID) non-steroidal anti-inflammatory drugs is diclofenac. Therefore, the current request cannot be determined as medically appropriate. There is also no evidence of failure to respond to first-line oral medication. Based on the clinical information received, the request is non-certified.

240ML OF TEROGIN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. As per the documentation submitted, there is no indication of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.

LEFT KNEE BRACE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a brace can be used for patellar instability, ACL tear, or MCL instability. In all cases, braces need to be properly fitted and combined with a rehabilitation program. A brace is only necessary if the patient is going to be stressing the knee under load. As per the documentation submitted, there is no evidence of this patient's active participation in a rehabilitation program. There is also no documentation of significant instability of the left knee. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is non-certified.