

Case Number:	CM14-0006216		
Date Assigned:	03/03/2014	Date of Injury:	06/07/2000
Decision Date:	06/30/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/16/2014

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 Orthopedic Surgery and is licensed to practice in 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 injured worker is a 54 year old female injured on 06/07/2000 when she tripped over a pallet causing her to fall backwards resulting in injuries to her right shoulder, back, and left leg. Diagnoses included chronic pain syndrome, epdural fibrosis, status post lumbar fusion in 2001, spondylolisthesis, L4-5, stasus post spinal cord stimulator implantation in 2011, right shoulder impingement syndrome, rule out medial meniscal tear to right knee, urological diagnosis, and psychological diangosis. Prior Utilization review indicates the injured worker presented on 11/21/13 with complaints of persistent low back pain and right knee pain. Physical examination revealed tenderness along the right medial joint line of the knee. Previous treatments included lumbar epidural steroid injections, TENS trial, right shoulder injection, and peripheral nerve stimulator to the tibial nerve. The most recent clinical note provided for review was dated 11/01/12. The original request for home health care assistance 4 hours/7 days a week and Dendracin lotion was non-certified on 12/30/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME HEALTH CARE ASSISTANCE 4 HOURS/7 DAYS A WEEK.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
HOME HEALTH SERVICES Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines HOME HEALTH SERVICES Page(s): 51.

Decision rationale: As noted on page 51 of the Chronic Pain Medical Treatment Guidelines, home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. There is no indication in the documentation provided that the injured worker requires home services due to homebound status. Additionally, the request does not specify the services that the injured worker requires specialized assistance with to establish medical necessity. As such, the request for home health care assistance 4 hours/7 days a week cannot be recommended as medically necessary at this time.

DENDRACIN LOTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, 111-113

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no current clinical documentation to establish the medical necessity of the requested medication. Further, CA MTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore Dendracin Lotion cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.