MAXIMUS Federal Services

Case Number:	CM14-0119234		
Date Assigned:	08/08/2014	Date of Injury:	10/13/2010
Decision Date:	09/18/2014	UR Denial Date:	07/02/2014
Priority:	Standard	Application Received:	07/29/2014

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 Family Medicine and is licensed to practice in Arizona. 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 75 year old male with a date of injury on 10/13/2010. Diagnoses include exacerbation of bilateral shoulder strain and bilateral knee strain. Prior diagnoses include bilateral knee osteoarthritis, bilateral medial and lateral meniscal tears, and right shoulder rotator cuff tear. Subjective complaints are of right shoulder and bilateral knee pain. Physical exam shows tenderness over the bilateral shoulders, upper arm and positive impingement tests. The bilateral knees showed tenderness, bilateral positive McMurray's test, and decreased knee flexion. Lower extremity strength was 4/5 and there was decreased sensation in bilateral legs. The patient had a shoulder MRI in 2011 which did not indicate recent trauma or change in his prior condition.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Radiography.

Decision rationale: The Official Disability Guidelines states that shoulder x-rays are indicated for acute shoulder trauma. It also states that the preferred imaging modality for patients with suspected rotator cuff disorders is MRI. The ACEOM states that cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen. This patient has had a prior MRI, and there is no documented evidence of recent acute trauma. Therefore, the medical necessity for shoulder x-rays is not established.

X-ray of the bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

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

Decision rationale: The ACOEM indicates that most knee problems improve quickly once any red-flag issues are ruled out. The Official Disability Guidelines indicates that knee x-rays are recommended for acute trauma to the knee. For this patient, there is no evidence of acute injury, and osteoarthritis has been previously documented by MRI. Therefore, the medical necessity of knee x-rays is not established.

Bilateral knee sleeve brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Braces.

Decision rationale: ACOEM guidelines support bracing as optional when used as part of a rehabilitation program. The Official Disability Guidelines supports knee braces for patients with knee instability, ligament insufficiency, articular defect, avascular necrosis, or meniscal cartilage repair. This patient does not show objective evidence of instability, or recent surgery or ongoing rehabilitation program. Therefore, the medical necessity of a knee sleeve is not established.

Hot and cold unit: 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), Knee & Leg (Acute & Chronic), Shoulder (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Hot /Cold Packs and Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines states that hot packs had no beneficial effect on edema compared with placebo or cold application. Ice packs did not affect pain significantly compared to control in patients with knee osteoarthritis. Continuous flow cryotherapy units are recommended as an option after surgery, but not for nonsurgical treatment. Therefore, the medical necessity for a hot and cold unit is not established.

Interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 118-119.

Decision rationale: The California MTUS does not recommend interferential current stimulation as an isolated intervention. The California MTUS does suggest it is possibly appropriate to have a one month trial if the following criteria are meet: Pain is ineffectively controlled due to diminished effectiveness of medications; Pain is ineffectively controlled with medications due to side effects, or there is significant pain from postoperative or acute conditions that limits the ability to perform exercise programs/physical therapy treatment. For this patient, there is no documentation of a one month trial, or ongoing rehabilitation program. Therefore the medical necessity of an interferential current unit is not established.

Flurbiprofen 20%, Tramadol 20% in Mediderm base 240gm: Upheld

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

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

Decision rationale: Chronic Pain Guidelines are clear that if the medication contains one drug that is not recommended the entire product should not be recommended. Guidelines do not recommend topical tramadol as no peer-reviewed literature support their use. The California MTUS indicates that topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but with a diminishing effect over another 2-week period. The California MTUS also indicates that topical NSAIDS are not recommended for neuropathic pain as there is no evidence to support their use. Therefore, the use of this medication is not consistent with guideline recommendations, and the medical necessity is not established.

Gabapentin 10%, Amitriptyline 10%, Dextromethorphan 10% in Mediderm base 240gm: Upheld

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

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

Decision rationale: Chronic Pain Guidelines are clear that if the medication contains one drug that is not recommended the entire product should not be recommended. Guidelines do not recommend topical Gabapentin as no peer-reviewed literature support their use. Guidelines also do not recommend topical Amitriptyline as no peer-reviewed literature support their use. Therefore, the use of this medication is not consistent with guideline recommendations, and the medical necessity is not established.