MAXIMUS Federal Services

Case Number:	CM14-0022907		
Date Assigned:	06/27/2014	Date of Injury:	04/14/2011
Decision Date:	08/05/2014	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	02/24/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Oklahoma. 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 39-year-old male who reported an injury on 04/14/2011. The mechanism of injury was not provided for clinical review. The diagnoses include lumbosacral disc disease, right inguinal hernia, umbilical hernia, ventral hernia. Previous treatments include surgery, medication, and physical therapy. Within the clinical note dated 01/23/2014, the injured worker stated he had less pain to his right shoulder, low back, neck, belly button, right knee and ankle; indicated he had improved with the therapy and medications. The medications helped his spasms. Upon the physical examination the provider noted tenderness to L3-5, T6-T12, right acromioclavicular (AC) subacromial bursa, and right medial joint line of the knee with improving range of motion. The provider requested for an interferential (IF) unit, FCMC cream, and Keto Cream. However, a rationale was not provided for clinical review. The Request for Authorization was submitted and dated on 02/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF unit: 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 Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: The request for an interferential (IF) unit is non-certified. The injured worker reported having less pain to his right shoulder, low back, neck, belly button, right knee, and ankles. The California MTUS Guidelines note interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments including return to work, exercise, and medication, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back, jaw, soft tissue, shoulder, cervical neck, and postoperative knee. The request submitted failed to provide the treatment site. The request submitted failed to provide the length of duration for treatment the provider is requesting. The guidelines do not recommend the IF unit for an isolated intervention. Therefore, the request is non-certified.

FCMC cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topicals Page(s): 143.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The request for FCMC cream is non-certified. The injured worker reported having less pain to his right shoulder, low back, neck, belly button, right knee and ankle. The California MTUS The MTUS guidelines note topical non-steroidal anti-inflammatory drugs (NSAIDs) are recommended for the treatment of osteoarthritis and tendinitis, in particular that of the knee and/or elbow, and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or knee. The request submitted failed to provide the frequency and quantity of the medication. The request does not specify a treatment site. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since at least 04/2013, which exceeds the guidelines recommendation of short term use of 4 to 12 weeks. Therefore, the request is non-certified.

Keto cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topicals Page(s): 143.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The request for Keto Cream is non-certified. The injured worker reported less pain to his right shoulder, low back, neck, belly button, right knee and ankle. The California

MTUS Guidelines note topical non-steroidal anti-inflammatory drugs (NSAIDs) are recommended for use in treatment of osteoarthritis and tendinitis, in particular that of the knee and/or elbow, and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for osteoarthritis of the hip, spine, or shoulder. The MTUS guidelines note ketoprofen is not currently approved by the Food and Drug Administration (FDA) for topical application. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency and quantity of the medication. The request submitted failed to provide a treatment site. The injured worker has been utilizing the medication for an extended period of time, since at least 04/2013, which exceeds the guidelines recommendation of short term use of 4 to 12 weeks. Therefore, the request is non-certified.