MAXIMUS Federal Services

Case Number:	CM14-0030080		
Date Assigned:	06/20/2014	Date of Injury:	10/29/2009
Decision Date:	08/15/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	03/10/2014

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 and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 59 year-old female was reportedly injured on October 29, 2009. The mechanism of injury is noted as a trip and fall type event. The most recent progress note, dated April 4, 2014, indicates that there are ongoing complaints of facial pain, bilateral shoulder, bilateral knee, right wrist and neck pain. The physical examination demonstrated a hypertensive (blood pressure reading 157/99) individual with tenderness on the right knee and no instability. Changes consistent with a right shoulder impingement are noted. Diagnostic imaging studies demonstrated intra-articular knee pathology resulting in a knee surgery. Previous treatment includes significant weight loss (80 pounds), cervical fusion, bilateral knee braces, cervical collar, Transcutaneous Electrical Nerve Stimulation (TENS) unit, plain radiographs, psychiatric and chiropractic care. A request was made for additional imaging studies, additional durable medical equipment and medications and was not certified in the pre-authorization process on February 18, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

DonJoy knee brace for the left knee (qty: 1): 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.

Decision rationale: As noted in the electronic version of the ACOEM guidelines, there is No Recommendation for Brace for all Acute, Sub-Acute and Chronic Knee disorders (Insufficient Evidence (I)). When noting the date of injury, the weight loss, and the current clinical assessment there is insufficient data to support the need for a knee brace. There is no objectified instability, or other pathology to suggest the need for such a brace. Plain films are reported to be pending, and there is no indication of a need for such a brace resented. Therefore, the medical necessity has not been established.

Collar with gel for the neck (qty: 1): 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), Treatment Index, Current Edition (web), current year, Knee Section, Cervical collars.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back (acute & chronic) updated August 4, 2014.

Decision rationale: It is noted that the MTUS/ACOEM guidelines do not address this topic. The Official Disability Guidelines (ODG) was used. Cervical collars are not recommended for soft tissue injuries or single level fusion surgeries. Based on the limited clinical information presented for review, there is no medical necessity for such a device.

TENS pads (qty: 1): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Neuromuscular Stimulation (TENS) Page(s): 114-115.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 113-116.

Decision rationale: When considering the date of injury, the findings noted on the most current physical examination reported, tempered by the parameters outlined in the MTUS such a device is not recommended. It is understood that a device has been purchased however there is no noted efficacy or utility with this device, there is no decrease in pain complaints, or increase functionality. Therefore, there is no medical necessity established for the use of this device or the attendant pands.

Hot and Cold wrap for the right wrist (qty: 1.00): 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), 18th Edition, 2013. Carpal Tunnel Chapter, Cold Packs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist, & hand chapter updated February 18, 2014.

Decision rationale: The use of topical cold compresses is supported in the acute phase of the injury. When noting the date of injury, the treatment rendered to date, the current physical examination there is no medical necessity for a cold wrap at this point.

MRI of the left knee (qty: 1.00): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, Current Edition (web), current year, Knee Chapter, Indications for imaging --MRI (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

Decision rationale: It is noted that a partial medial and lateral meniscectomy has been completed. However, there are no physical examination findings establishing any ligamentous instability, capsular strain, intra-articular pathology or any other malady that require enhanced imaging studies. Accordingly, based on the lack of any clinical information relative to the knee the medical necessity for this study has not been established.

Standing X-Ray of the left knee (qty: 1.00): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, Current Edition (web), current year, Knee Chapter, Indications for Imaging --X-Rays.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chapter updated June, 2014.

Decision rationale: When noting the injury sustained, the surgical intervention of a partial medial and lateral meniscectomy, the inference that there is significant degenerative changes requiring viscosupplementation there is a clinical indication for a standing x-ray of the need to establish the severity of the degenerative changes. Therefore, a standing x-ray to assess the ordinary disease of life degenerative changes would be clinically indicated and medically necessary.

Physiatrist consultation for the neck (qty: 1.00): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice

Guidelines, 2nd Edition, 2004, Chapter 7: Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), ACOEM Practice Guidelines, 2nd edition, Chapter 7 - Independent Medical Examinations and Consultations, pg 127.

Decision rationale: When noting the date of injury, the multiple clinical evaluations already completed and that there is no uncertainty as to the diagnosis there is limited clinical information presented to suggest the need for a physiatry consultation. Therefore, based on the records presented for review the medical necessity has not been established.

Prescription of Norco 10mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Ongoing Management) Page(s): 78-80, 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-78.

Decision rationale: This opioid analgesic is indicated for the short-term treatment of moderate to severe breakthrough pain. When noting the date of injury, the multiple complaints of pain and there is no objectified efficacy or utility with the utilization of this medication, the medical necessity for its continued use has not been established.

Prescription of Flexeril 10mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Page 41 and Muscle Relaxants Page(s): 41, 64.

Decision rationale: This muscle relaxant type medication is recommended for a short course of therapy. There is no clinical indication for the chronic or indefinite use of this medication. There are subjective complaints of muscle spasm but the physical examination failed to identify or objectified such a malady. Therefore, the medical necessity for the continued use of this preparation has not been established.

Prescription of LidoPro Cream 4oz, #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56.

Decision rationale: The MTUS supports the use of topical lidocaine for individuals with neuropathic pain that have failed treatment with first-line therapy including antidepressants or anti-epilepsy medications. Based on the clinical documentation provided, there is no competent, objective and independently confirmable medical evidence of any profile neuropathy, radiculopathy or neuropathic pain generator. As such, the request is considered not medically.

Prescription of Terocin Patches, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: This is a topical preparation that includes methyl salicylate, capsaicin, menthol and lidocaine. As outlined in the MTUS, any a topical compounded preparation that includes one product that is not clinically indicated obviates the entire product. Given that there is no objective data to suggest a neuropathic pain lesion, use of topical lidocaine would be excluded. Therefore, based on a clinical information presented for review the medical necessity for this product is not been established.