

Case Number:	CM14-0051004		
Date Assigned:	08/01/2014	Date of Injury:	04/07/2010
Decision Date:	10/16/2014	UR Denial Date:	03/07/2014
Priority:	Standard	Application Received:	03/20/2014

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 56-year-old female was reportedly injured on April 7, 2010. The most recent progress note, dated March 20, 2014, indicates that there are ongoing complaints of low back pain and bilateral knee pain. Current medications include tramadol and Restoril. The physical examination demonstrated decreased lumbar spine range of motion and tenderness along the right greater than the left paraspinal muscles. There was a positive right-sided straight leg raise test at 70 and a positive Kemp's test. Decreased strength was noted bilaterally at L4, L5, and S1 and there was decreased sensation at L4. Examination of the bilateral knees noted decreased range of motion. There was tenderness at the medial joint line of the right knee with mild swelling. There was a positive varus and valgus stress test and a positive McMurray's test on the left knee. Diagnostic imaging studies were not reviewed during this visit. Previous treatment includes physical therapy and oral medications. A request had been made for 12 physical therapy sessions, a protein rich plasma injection for the right knee, Keratek gel, and Restoril and was not certified in the pre-authorization process on March 7, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 PHYSICAL THERAPY SESSIONS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Physical Therapy, Updated August 22, 2014.

Decision rationale: According to the Official Disability Guidelines 10 visits of physical therapy are recommended for sprains and strains of the lower back. As this request is for 12 visits of physical therapy, this request is not medically necessary.

1 PROTIEN RICH PLASMA INJECTION FOR THE RIGHT KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILTIY GUIDELINES

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Protein Rich Plasma, Updated October 7, 2014.

Decision rationale: According to the Official Disability Guidelines the use of platelet rich plasma is under study for use in the knee. There is need for further basic science investigation as well as randomized controlled trials to identify the benefits, side effects, and adverse effects that may be associated with use of PRP. Additionally, it is not stated at what structure in the knee is to be injected. For these reasons, this request for a protein rich plasma injection for the right knee is not medically necessary.

1 PRESCRIPTION OF KERA-TEK ANALGESIC GEL, 4 OZ: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 111-112 of 127.

Decision rationale: Keratek gel is a compound of menthol and methyl salicylate. According to the California Chronic Pain Medical Treatment Guidelines the only topical analgesic medications indicated for usage include anti-inflammatories, lidocaine, and capsaicin. There is no known efficacy of any other topical agents. Per the MTUS, when one component of a product is not necessary the entire product is not medically necessary. Considering this, the request for Keratek Analgesic Gel is not medically necessary.

RESTORIL 15 MG, # 30: 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 8 C.C.R. 9792.20 -9792.26; MTUS (Effective July 18, 2009) Page(s): 24 of 127..

Decision rationale: Restoril is a benzodiazepine and is used on a short-term basis for the treatment of insomnia. Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. A review of the attached medical record indicates that this medication has been prescribed for long-term usage. As such, Restoril 15 MG is not medically necessary.