

Case Number:	CM14-0073343		
Date Assigned:	07/16/2014	Date of Injury:	09/09/2009
Decision Date:	08/25/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	05/20/2014

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, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 43 year old male with date of injury 9/9/09. The treating physician report dated 4/22/14 indicates that the patient presents with chronic pain affecting the cervical spine rated a 7/10 with radiation to the bilateral upper extremities down to the hands with paresthesia, headaches, lower back pain 8/10 with radiation down to the feet, right elbow pain 7/10, right knee pain 7/10, acid reflux, anxiety, depression and stress. The patient's current diagnoses are status post interlaminar laminotomy to the left L5/S1, disc protrusion at C4/5 and C5/6, cervical, thoracic and lumbar myofascial pain syndrome and right knee s/s. The utilization review report dated 5/16/14 denied the request for ergonomic chair for home use, orthopedic mattress, Flurbiprofen cream, Ketoprofen cream and Gabapentin cream based on the MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ergonomic chair for home use: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck Chapter, Ergonomics; Low Back chapter: Ergonomics Interventions.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Durable Medical Equipment.

Decision rationale: The patient presents with chronic neck and back pain with bilateral upper and lower extremity pain as well as right knee pain. The current request is for ergonomic chair for home use. The treating physician states, the patient will continue using his one-year gym membership and massage chair. In addition, he is recommended to use an ergonomic chair for home use. Moreover, the patient is recommended to use an orthopedic mattress. There is no medical rationale supporting the request for an ergonomic chair for home use. The MTUS guidelines do not address chairs. The ODG guidelines knee chapter for durable medical equipment (DME) states that if there is a medical need and if the device meets Medicare's definition of DME then the request may be supported. In this case there is no medical necessity documented why an ergonomic chair is needed at home. The physician does not indicate that the patient is working from home. Therefore the request is not medically necessary.

Orthopedic mattress: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Mattress Selection.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mattress selection.

Decision rationale: The patient presents with chronic neck and back pain with bilateral upper and lower extremity pain as well as right knee pain. The current request is for an orthopedic mattress. The treating physician states, the patient will continue using his one-year gym membership and massage chair. In addition, he is recommended to use an ergonomic chair for home use. Moreover, the patient is recommended to use an orthopedic mattress. There is no medical rationale supporting the request for an orthopedic mattress. The MTUS guidelines do not address mattresses. The ODG guidelines lumbar chapter for mattress selection states, there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. In this case there is no medical evidence to support an orthopedic mattress and the ODG guidelines do not support this request. Therefore the request is not medically necessary.

Flurbiprofen 20% cream 120 g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; Topical Analgesics Page(s): 60-61; 111-113.

Decision rationale: The patient presents with chronic neck and back pain with bilateral upper and lower extremity pain as well as right knee pain. The current request is for Flurbiprofen 20% cream 120 g. The treating physician has prescribed this topical cream to treat the knee due to osteoarthritis, pain, stiffness and swelling. The MTUS guidelines support the usage of Flurbiprofen 20% cream (NSAID) for the treatment of osteoarthritis and tendinitis of the knee and elbow or other joints that are amenable to topical treatment. This patient presents with right knee pain for which topical NSAID is indicated. However, MTUS page 60 requires that pain and function be documented when medications are used for chronic pain. In this case, the physician does not discuss whether or not this topical product reduces the patient's pain and improves function. Therefore the request is not medically necessary.

Ketoprofen 20%/ ketamone 10% cream, 120g: 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: The patient presents with chronic neck and back pain with bilateral upper and lower extremity pain as well as right knee pain. The current request is for Ketoprofen 20%/ Ketamine 10% cream, 120g. The treating physician has prescribed this topical cream to treat the knee due to osteoarthritis, pain, stiffness and swelling. The MTUS guidelines regarding Ketoprofen state, this agent is not currently FDA approved for a topical application. This patient presents with right knee pain for which topical Ketoprofen is not supported by the MTUS guidelines. Therefore the request is not medically necessary.

Gabapentin 10%/ capsaicin 0.0375% cream 120 g, apply on the affected area two to three times a day: 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: The patient presents with chronic neck and back pain with bilateral upper and lower extremity pain as well as right knee pain. The current request is for Gabapentin 10%/ Capsaicin 0.0375% cream 120 g, apply on the affected area two to three times a day. The treating physician has prescribed this topical cream to treat the knee due to osteoarthritis, pain, stiffness and swelling. The MTUS Guidelines do not support any topical analgesics that contain Gabapentin. Therefore the request is not medically necessary.