

Case Number:	CM14-0086688		
Date Assigned:	08/08/2014	Date of Injury:	03/01/2013
Decision Date:	09/12/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	06/09/2014

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 Orthopedic Surgery 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:

This is a 51-year-old gentleman who sustained a vocational injury on 03/01/13. The medical records provided for review include an office note dated 07/11/14 with diagnoses documented on the office note of cervical spine sprain and strain with discogenic pain and left knee pain with a medial meniscus tear. Subjective complaints were occasional cervical spine pain, worse with prolonged standing and walking, and bilateral wrist and left knee pain. Examination was documented to show tenderness of the cervical spine in the paraspinal region; left knee flexion limited to 100 degrees and extension to 10 degrees. It was documented that an MRI was performed, which showed a meniscus tear of the knee. The first request was for Mentherm Gel 360 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Mentherm Gel 360gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded Medications, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Topical Analgesics and Compounded Agents.

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

Decision rationale: California Chronic Pain Medical Treatment Guidelines recommend that topical analgesics are considered largely experimental and should not be considered as first line treatment for orthopedic or musculoskeletal conditions. Currently, documentation presented for review does not establish the medical necessity of the requested procedure and there is a lack of documentation that the claimant has failed traditional first-line conservative treatment options such as anti-inflammatories, activity modification, rest, ice, heat, Tylenol, formal physical therapy, activity modification, or injection therapy. Therefore, based on the documentation presented for review and in accordance with California Chronic Pain Medical Treatment Guidelines, the request for the Menthoderm Gel 360 gm cannot be considered medically necessary.

Omeprazole 20mg #30, no refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: California Chronic Pain Guidelines recommend that omeprazole should only be used if there is a risk of gastrointestinal events specifically in the elderly population. Documentation presented for review does not suggest that the patient suffers from any history of peptic ulcer disease, GI bleeding or perforation, gastroesophageal reflux disorder, concurrent use of aspirin, corticosteroids, anticoagulants, or high dose/multiple NSAID use and the claimant is not older than 65 years of age and subsequently the request cannot be considered medically necessary.

Tramadol ER 150mg #30, no refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 75, 93-94, 113.

Decision rationale: The previous utilization review determination recommended modifying the request for Tramadol with recommendations to wean off of the medication. The Chronic Pain Guidelines recommend that Tramadol should be considered in the acute pain setting and should not be recommended as a maintenance medication. Records presented for review fail to establish the claimant has had a recent urine drug test, risk assessment profile, or attempted weaning and tapering of the medication as previously recommended. In addition, there is a lack of documentation the claimant has failed traditional first-line medications used to treat the current working diagnoses, which should include anti-inflammatories, and/or Tylenol prior to considering pain medication such as Tramadol (Ultram). Therefore, based on the documentation presented for review and in accordance with California Chronic Pain Guidelines, the request for

the Tramadol Extended Release 150 mg dispensed #30 cannot be considered medically necessary.

Internal Medicine (IM) Consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004); Chapter 7, page 127.

Decision rationale: California MTUS ACOEM Guidelines suggest that referral to a specialist may be appropriate if a diagnosis is uncertain or extremely complex or when the plan or course of care may benefit from additional expertise. Documentation presented for review fails to establish the medical necessity of the requested internal medicine consult as there is no documentation of a clear medical rationale for the requested consultation. Therefore, based on the documentation presented for review and in accordance with California MTUS ACOEM Guidelines, the request for the internal medicine consult cannot be considered medically necessary.

Gel Trial:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded Medications, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Topical Analgesics and Compounded Agents.

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

Decision rationale: Currently the request is not specific for what a gel trial is or what the requested gel is. Documentation presented for review failed to establish any specific medical rationale for the requested medication. In absence of specific identification of the gel trial, the request for the gel trial cannot be considered medically necessary.

Acupuncture 2 times a week for 4 weeks for bilateral wrists, bilateral shoulders, cervical spine, left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Acupuncture Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated and should be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Currently, there is no documentation suggesting the claimant has attempted, failed and exhausted traditional first-line conservative treatment options prior to recommending and considering a course of acupuncture therapy. In addition, there is no clear medical rationale as to how the request for acupuncture would decrease subjective complaints and abnormal physical exam objective findings and overall increase both short and long term functional vocational progress. There is no documentation of a structured rehabilitation plan provided. Therefore, based on the documentation presented for review and in accordance with California MTUS ACOEM Guidelines, the request for the acupuncture therapy cannot be considered medically necessary.

Post-op Physical Therapy 2 times a week for 6 weeks for left knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Knee, Physical Therapy, Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The documentation presented for review fails to establish when the claimant had left knee surgery and what the procedure or intraoperative findings were at that time. The request is for postop physical therapy and prior to considering medical necessity, it would be imperative to know the surgical intervention date, the procedure performed, intraoperative findings noted, and how much physical therapy the claimant has had to date and if there has been any significant quantifiable objective improvement. Due to the lack of documentation presented for review, the request for the left knee postop physical therapy times 12 sessions cannot be considered medically necessary.

Right Wrist Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Wrist, Hand: Immobilization.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 263-264. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Forearm, Wrist and Hand chapter: Immobilization (treatment).

Decision rationale: California MTUS ACOEM Guidelines and the Official Disability Guidelines do not recommend the use of a right wrist brace. The ACOEM Guidelines support night splints for the diagnosis of carpal tunnel as well as immobilization in the form of splinting or casting as a primary treatment for non-displaced fractures or sprains. Official Disability Guidelines suggest that early immobilization benefits include early return to work, decreased pain, swelling and stiffness and a greater, preserved range of joint motion with no increased

complications. Currently, there is no documentation of abnormal objective findings or a diagnosis provided, which would be responsive to treatment with a right wrist brace and subsequently, based on documentation presented for review and in accordance with California MTUS ACOEM Guidelines and Official Disability Guidelines, the request for the right wrist brace cannot be considered medically necessary.