

Case Number:	CM14-0201507		
Date Assigned:	12/11/2014	Date of Injury:	10/27/2010
Decision Date:	02/03/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/01/2014

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 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:

This patient is a 55-year-old male with a date of injury of October 27, 2010. According to treatment report dated September 30, 2014, the patient presents with neck pain that is rated as 7/10, low back pain rated as 6/10, left knee pain rated as 3/10 and bilateral feet and hand pain described as numbness and tingling. The patient has completed a course of Aquatic therapy which has helped with the symptoms. The patient is currently taking Norco, Oxycodone and Lyrica. Examination of the cervical spine revealed tenderness in the bilateral cervical paraspinal at the C4-5 and C5-6. Range of motion was within normal limits. Examination of the lumbar spine revealed tenderness and spasm in the lumbar paraspinal bilaterally. Range of motion was within normal limits. Examination of the bilateral knee revealed tenderness in the medial joint and lateral joint line. McMurray's test was positive. The listed diagnoses are: 1. Cervical disc syndrome 2. Lumbar disc syndrome 3. Left knee osteoarthritis 4. Tear of medial cartilage or meniscus of the left knee 5. Status post left knee arthroscopic 6. Status post tibial plateau fracture a 2002 The patient is currently temporarily totally disabled. The treatment plan was for acupuncture treatment two times a week for four weeks, medications, orthopedic mattress, and home health care assessment. The utilization review denied the requests on November 17, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Health Care Assessment 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), Home Health Services

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines home services Page(s): 51.

Decision rationale: This patient presents with neck, low back, knee and bilateral feet and hand pain. The current request is for home health care assessment qty 1. The MTUS page 51 has the following regarding home services, "recommended only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis generally up to no more than 35 hours per week." In this case, there are no significant physical findings that would require a home healthcare aide. There are no discussions regarding the patient's specific functional needs that would require assistant and the medical justification for the deficits. MTUS recommends home health care assistant for patients that require medical treatment and that are homebound. The patient does not meet the criteria for home health care assistance; therefore, the requested home health care assessment IS NOT medically necessary.

Orthopedic Mattress 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),

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 - Lumbar & Thoracic Chapter, Mattress Selection & Tempur-Pedic mattress.

Decision rationale: This patient presents with neck, low back, knee and bilateral feet and hand pain. The current request is for orthopedic mattress QTY: 1.00. The MTUS and ACOEM guidelines do not discuss Tempur-Queen Bed and frame. (ODG) Low Back - Lumbar & Thoracic Chapter, Mattress Selection & Tempur-Pedic mattress references a recent clinical trial that concluded patients with medium-firm mattresses have better outcomes than patients with firm mattresses for pain in bed, pain on rising, and stability. In addition, ODG guidelines states that a medium-firm mattress can have better outcomes from non-specific back pain but that this is still under study. ODG definitively 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. Mattress selection is subjective and depends on personal preference and individual factors. On the other hand, pressure ulcers (e.g., from spinal cord injury) may be treated by special support surfaces (including beds, mattresses and cushions) designed to redistribute pressure. In this case, the treating physician is not recommending a mattress for the treatment of pressure ulcers and ODG does not support the usage of a mattress for the treatment of low back pain. The requested mattress IS NOT medically necessary.

Acupuncture Treatment QTY: 8.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines
http://www.dir.ca.gov/dwc/DWCPropRegs/MedicalTreatmentUtilizationSchedule/MTUS_FinalCleanCopy.d.

Decision rationale: This patient presents with neck, low back, knee and bilateral feet and hand pain. The current request is for Acupuncture Treatment Qty: 8.00. The Utilization review modified the certification from the requested 8 treatments to 6 treatments. For acupuncture, the MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. The recommended frequency and duration is 3 to 6 treatments for a trial and with functional improvement, 1 to 2 times per day with optimal duration of 1 to 2 months. The medical file does not indicate that the patient has trialed acupuncture treatments. Given the patient's continued pain, an initial course of 3-6 sessions may be warranted. In this case, the treating physician's request for a trial of 8 treatments exceeds what is recommended by MTUS. This request IS NOT medically necessary.

Cyclobenzaprine 2% Cream (60 gram tube) QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Topical Analgesics

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

Decision rationale: This patient presents with neck, low back, knee and bilateral feet and hand pain. The current request is for Cyclobenzaprine 2% cream (60 gram tube) Qty: 1.00. The treating physician states that this topical cream was dispensed "to reduce spasm, pain, increase function and mobility as well as decrease the need for additional oral medication." The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." In this case, cyclobenzaprine is a muscle relaxant and not recommended in any topical formulation. This request IS NOT medically necessary.

Ibuprofen 10% Cream (60 gram tube) QTY: 1.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Topical Analgesics

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

Decision rationale: This patient presents with neck, low back, knee and bilateral feet and hand pain. The current request is for Ibuprofen 10% cream (60 gram tube) QTY: 1.00. The treating physician states that this topical cream was dispensed "as an anti-inflammatory to reduce pain, increase function and mobility as well as decrease the need to additional oral medication." The Utilization review denied the request stating that "there is no documentation of the patient's intolerance of these or similar medications to be taken on an oral basis." The MTUS Guidelines page 111 has the following regarding topical creams, "Topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety." The MTUS Guidelines support the usage of salicylate (NSAID) topical for osteoarthritis and tendinitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. In this case, the patient has continued bilateral knee complaints and has a diagnosis of knee osteoarthritis. The treating physician has prescribed this medication in accordance with MTUS guidelines. The requested one tube of Ibuprofen topical cream IS medically necessary.