

Case Number:	CM14-0202593		
Date Assigned:	12/15/2014	Date of Injury:	11/17/2005
Decision Date:	02/17/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	12/03/2014

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:

43 year old male with reported industrial injury of 11/17/05. MRI left knee from 1/23/08 demonstrates small joint effusion and scarring within Hoffa's pad which is likely post surgical in nature. Exam note from 10/15/14 demonstrates patient presents with lumbar pain. Exam demonstrates moderate generalized tenderness in the lumbar area. Range of motion is noted to be full in the lumbar spine and knee. 5/5 strength is noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cryomodulation/Cryoablation Left Knee QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 38.

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 chapter, Continuous Flow Cryotherapy

Decision rationale: CA MTUS/ACOEM is silent on the issue of cryotherapy. According to Official Disability Guidelines (ODG), Knee and Leg chapter regarding continuous flow cryotherapy it is a recommended option after surgery but not for nonsurgical treatment. In addition, it is recommended for upwards of 7 days postoperatively. In this case, the request is for

cryomodulation/cryoablation in a non-operative setting; therefore, this request is not medically necessary.

Prilosec 20MG DR QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines, page 68, recommendation for Prilosec is for patients with risk factors for gastrointestinal events. The cited records from 10/15/14 do not demonstrate that the patient is at risk for gastrointestinal events. Therefore, this request is not medically necessary.

Cyclobenzaprine HCL 5MG QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42 "Recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better and treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended." In this case, the patient has no evidence in the records of 10/15/14 of functional improvement, a quantitative assessment on how this medication helps percentage of relief lasts, increase in function, or increase in activity. In addition, the chronic usage is not supported by the guidelines. Therefore, this request is not medically necessary.

Ultram ER 100MG QTY:30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

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

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents

such as non-steroidal anti-inflammatory drugs (NSAIDs) fail. There is insufficient evidence in the records of 10/15/14 of failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore, this request is not medically necessary.