MAXIMUS Federal Services

Case Number:	CM15-0104133		
Date Assigned:	06/11/2015	Date of Injury:	06/14/2013
Decision Date:	08/28/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/01/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Indiana, Oregon
Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 57 year old female, who sustained an industrial injury on 06/14/2013. She has reported subsequent neck, bilateral upper extremity, head and right knee pain and was diagnosed with internal derangement of the right knee, right upper extremity radiculopathy, headaches, pseudoarthrosis at C4-C5 and status post anterior cervical discectomy and fusion at C4-C7. Treatment to date has included oral and injectable pain medication, physical therapy and surgery. In a progress note dated 05/05/2015, the injured worker complained of constant neck pain with radiation to the bilateral upper extremities with associated numbness and tingling to the bilateral fingers, neck spasms, headaches and constant right knee pain. Objective findings were notable for tenderness and spasm throughout the neck with radiation to the interscapular region with positive Spurling's and cervical compression tests, medial joint line tenderness of the right knee with soft tissue swelling, positive patellofemoral grind, small to moderate effusion, crepitus with range of motion and positive duck walk, Steinman's and McMurray's tests. The physician noted that the injured worker had failed conservative therapy and a right knee arthroscopy with chondroplasty and synovectomy was recommended. A request for authorization of assistant surgeon, 24 sessions of post-operative physical therapy, 30-day rental of a cold therapy unit, transportation to and from the facility, Soma, Flurbiprofen, Ketoprofen/Ketamine cream, Gabapentin/Cyclobenzaprine/Capsaicin cream and a urine drug test was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Assistant surgeon: 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), Low Back Chapter; Surgical assistant.

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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of a surgical assistant. ODG low back is referenced. More complex cases based off CPT code are felt to warrant the use of a surgical assistant. The requested procedure is knee arthroscopy. Given the level of complexity of the surgery it is not felt to be medically necessary to have an assistant.

Post operative physical therapy, 24 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: According to the CA MTUS/Post Surgical Treatment Guidelines, Knee Meniscectomy, page 24, 12 visits of therapy are recommended after arthroscopy with partial meniscectomy over a 12-week period. The guidelines recommend initially of the 12 visits to be performed. As the request exceeds the initial allowable visits, the request is not medically necessary.

Associated surgical service: 30 day rental of a cold therapy unit: 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), Knee and Leg Chapter; Continuous-flow cryotherapy section.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of knee cryotherapy. According to ODG Knee Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case the requested length exceeds the guideline recommendations and is therefore not medically necessary.

Associated surgical service: Transportation to and from the facility: 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), Knee and Leg Chapter; Transportation and the Department of Health Care Services-California, Criteria Manual Chapter 12.1 Criteria for Medical Transportation and Related Services.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of transportation. According to the ODG, Knee and Leg Chapter, Transportation is recommended for patients with disabilities preventing them from self transport. In this case the exam note from 5/5/15 does not demonstrate evidence of functional impairment precluding self transportation including the use of public transportation. Therefore the request is not medically necessary.

Soma 350mg #60, one BID: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines carisoprodol Page(s): 29.

Decision rationale: Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 29, Carisoprodol (Soma), does not recommend Soma for long term use. It is a skeletal muscle relaxant, which has abuse potential due to its sedative and relaxant effects. In this case, the exam note from 5/5/15 does not demonstrate prior dosages and response to Soma. In addition, the guidelines do not recommend long term use. Therefore the request is not medically necessary.

Flurbiprofen 20% cream #120gm: 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.

Decision rationale: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Diclofenac is the only FDA approved topical NSAID. Other NSAIDs have a high rate of photosensitive reactions and are not recommended. This request is for a topical NSAID other than diclofenac, therefore the request is not medically necessary.

Ketoprofen 20% (120gm)/Ketamine 10% (120gm) in a cream base: 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.

Decision rationale: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Diclofenac is the only FDA approved topical NSAID. Other NSAIDs have a high rate of photosensitive reactions and are not recommended. Therefore the request is not medically necessary.

Gabapentin 10%, Cyclobenzaprine 10%, Capsaicin 0.0375% cream #120gm: 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. Decision based on Non-MTUS Citation Bryson, Evan, et al. "Skin Permeation and Antinociception of Compounded Topical Cyclobenzaprine Hydrochloride Formulations." International Journal of Pharmaceutical Compounding 19.2 (2015): 161.Argoff CE. Topical agents for the treatment of chronic pain. Curr Pain Headache Rep. 2006 Feb;10(1):11-9.

Decision rationale: Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Cyclobenzaprine is not supported for topical use based on the alternative guidelines submitted. Gabapentin is not recommended for topical use. Therefore the request is not medically necessary.

Urine drug test: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines urine toxicology Page(s): 94.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 94-95, use of urine toxicology is encouraged particularly when opioids are prescribed. It states, "Opioids, steps to avoid misuse/addiction. The following are steps to avoid misuse of opioids, and in particular, for those at high risk of abuse: a) Opioid therapy contracts. See Guidelines for Pain Treatment Agreement. b) Limitation of prescribing and filling of prescriptions to one pharmacy. c) Frequent random urine toxicology screens." In this case there is insufficient evidence of chronic opioid use or evidence of drug misuse to warrant urine toxicology. The request is not medically necessary.