MAXIMUS Federal Services

Case Number:	CM15-0202817		
Date Assigned:	10/19/2015	Date of Injury:	02/17/2014
Decision Date:	12/07/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	10/15/2015

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: Texas, Illinois
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 46 year old male, who sustained an industrial-work injury on 2-17-14. He reported initial complaints of neck, back, hips, knees, and right ankle pain. The injured worker was diagnosed as having insomnia, sprain-strain of bilateral hand, lumbar spine, left shoulder, elbow, right ankle, blurry vision, and groin pain. Treatment to date has included medication, 14 physiotherapy sessions, 29 chiropractic sessions, 46 therapeutic activities, interferential unit at home, and diagnostics. Currently, the injured worker complains of headaches, neck pain, upper back pain, low back pain, bilateral shoulder pain, right elbow pain, bilateral hip pain, right knee pain, right ankle pain, groin pain, abdominal pain, bilateral wrist-hand pain. Per the primary physician's progress report (PR-2) on 9-16-15, exam notes tenderness over the right paracervical musculature, positive diffuse tenderness in the thoracic region without associated spasm, tenderness over the radiocarpal joints, inability to make a full fist on the right hand with fingers missing the mid palmar crease by one half inch, tenderness over the metacarphalangeal and the proximal interphalangeal joints bilaterally, tenderness over the posteriolateral aspect of the right hip, tenderness over the lateral aspect of the right knee joint and positive McMurray's on the right knee. The Request for Authorization requested service to include KKGL Cream: Ketamine 10%, Ketoprofen 10%, Gabapentin 10%, Lidocaine 5%, 360 Gm, 4 Chiropractic Evaluation and Treatments To Neck, Upper Back, Low Back, Right Shoulder, and Supervised Exercises For The Right Knee and 1 IF 4 Unit for home use for the neck ,back and right shoulder. The Utilization Review on 9-21-14 denied the request for KKGL Cream: Ketamine 10%, Ketoprofen 10%, Gabapentin 10%, Lidocaine 5%, 360 Gm, 4

Chiropractic Evaluation and Treatments To Neck, Upper Back, Low Back, Right Shoulder, And Supervised Exercises For The Right Knee and 1 IF 4 Unit for home use for the neck, back and right shoulder, per CA MTUS (California Medical Treatment Utilization Schedule), Chronic Pain Medical Treatment Guidelines 2009.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kkgl Cream: Ketamine 10%, Ketoprofen 10%, Gabapentin 10%, Lidocaine 5%, 360 Gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The injured worker sustained a work related injury on 2-17-14. The medical records provided indicate the diagnosis of insomnia, sprain-strain of bilateral hand, lumbar spine, left shoulder, elbow, right ankle, blurry vision, and groin pain. Treatment to date has included medication, 14 physiotherapy sessions, 30 chiropractic sessions, 46 therapeutic activities, interferential unit at home. The medical records provided for review do not indicate a medical necessity for Kkgl Cream: Ketamine 10%, Ketoprofen 10%, Gabapentin 10%, Lidocaine 5%, 360 Gm. The MTUS does not recommend the use of any compounded topical analgesic that contains any agent that is not recommended. The MTUS does not recommend the use of Ketamine, Ketoprofen, Gabapentin, as topical analgesic. The request is not medically necessary.

4 Chiropractic Evaluation and Treatments To Neck, Upper Back, Low Back, Right Shoulder, And Supervised Exercises For The Right Knee: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The injured worker sustained a work related injury on 2-17-14. The medical records provided indicate the diagnosis of insomnia, sprain-strain of bilateral hand, lumbar spine, left shoulder, elbow, right ankle, blurry vision, and groin pain. Treatment to date has included medication, 14 physiotherapy sessions, 29 chiropractic sessions, 46 therapeutic activities, interferential unit at home. The medical records provided for review do not indicate a medical necessity for 4 Chiropractic Evaluation and Treatments To Neck, Upper Back, Low Back, Right Shoulder, And Supervised Exercises For The Right Knee. The MTUS has two approaches for chiropractic care. These are the Manual therapy and Manipulation guidelines, otherwise known as passive chiropractic care. This guidelines recommends up to 18 chiropractic visits. The second approach is the Physiotherapy approach or active therapy approach, which

follows the Physical Medicine guidelines of allowing for a fading treatment of 8-10 visits over 4-8 weeks. Therefore, although this request did not specify the specific approach that is being requested, the request is not medically necessary because the injured worker has exceeded the guidelines recommendation for either the passive or the active chiropractic care. Additionally, supervised exercise is not medically necessary because this follows the physical medicine approach, but the injured worker has already had 14 visits instead of the 10 visits recommended.

1 IF 4 Unit for home use for the neck, back and right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The injured worker sustained a work related injury on 2-17-14. The medical records provided indicate the diagnosis of insomnia, sprain-strain of bilateral hand, lumbar spine, left shoulder, elbow, right ankle, blurry vision, and groin pain. Treatment to date has included medication, 14 physiotherapy sessions, 29 chiropractic sessions, 46 therapeutic activities, interferential unit at home. The medical records provided for review do not indicate a medical necessity for 1 IF 4 Unit for home use for the neck, back and right shoulder. The medical records indicate the injured worker is off work. The MTUS states that Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Therefore, the requested treatment is not medically necessary.