

<b>Case Number:</b>	CM15-0020195		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	05/03/2006
<b>Decision Date:</b>	05/20/2015	<b>UR Denial Date:</b>	01/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 59 year old male, who sustained a work/ industrial injury on 5/3/06. He has reported symptoms of low back pain with associated right leg pain along with neck pain with headaches. Prior medical history included obesity, obstructive sleep apnea, and hypertension. The diagnoses have included lumbar discopathy with facet arthropathy, right knee tendinitis, s/p right total knee arthroplasty, headaches, anxiety, and depression. Treatments to date included medication, brace, neurology consult, surgery, and cane. Exam noted antalgic gait with use of a cane, inability for heel /toe walk, limited range of motion to the lumbar area, positive straight leg raise bilaterally, weakness in the right lower extremity, right knee joint line tenderness, and pain with partial deep knee bend to approximately 90-95 degrees, and tenderness and spasm with tightness to the paralumbar musculature. The treating physician requested one right hinged knee brace, one lumbar spine support, 10 week [REDACTED] weight loss program, one prescription of Ultram and Ibuprofen, along with a topical compound of Gabapentin, Cyclobenzaprine, Ketoprofen, capsaicin, menthol, camphor, Ketoprofen, Cyclobenzaprine, lidocaine cream, and orthopedic re-evaluation within 6 weeks. On 1/27/15, Utilization Review non-certified one right knee brace; one lumbar spine support; 10 week [REDACTED] weight loss program; One prescription of Ultram 50 mg #60 with 2 refills; One prescription of Ibuprofen 800 mg #90 with 2 refills; One prescription of Gab/cyclo/deto/caps/menth/camp cream 10/4/10/0.0375/5/2%; One orthopedic re-evaluation within 6 weeks, noting the California Medical treatment Utilization Schedule (MTUS)

Guidelines and American College of Occupational and Environmental Medicine (ACOEM) Guidelines, and Official Disability Guidelines (ODG).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**One right knee brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 339-340.

**Decision rationale:** The ACOEM Guidelines indicate that a brace can be used for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability. For the average patient, a brace is generally unnecessary. The brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. The clinical documentation submitted for review indicated the injured worker had a prior brace. There was a lack of documentation indicating a necessity for a second brace. Additionally, there was a lack of documentation indicating the injured worker was going to be stressing the knee under load, such as climbing ladders or carrying boxes. Given the above, the request for 1 right knee brace is not medically necessary.

**One lumbar spine support:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** The American College of Occupational and Environmental Medicine guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, continued use of back braces could lead to deconditioning of the spinal muscles. The clinical documentation submitted for review failed to provide documentation the injured worker had spinal instability upon physical examination. Given the above, the request for 1 lumbar spine support is not medically necessary.

**10 week [REDACTED] weight loss program:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Snow V, Barry P, Fitterman N, Oaseem A, Weiss K. Pharmacologic and surgical management of obesity in primary care: a clinical practice guideline from the American College Physicians. Ann Intern Med 2005 Apr 5;142 (7):525-31.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes Chapter, Lifestyle (diet & exercise) modifications.

**Decision rationale:** The Official Disability Guidelines indicate that lifestyle, diet and exercise modifications are recommended as first line interventions. The clinical documentation submitted for review indicated the injured worker was obese. However, the BMI was not provided. There was a lack of documented rationale for the requested [REDACTED] program. There was a lack of documentation indicating the injured worker had a failure with diet and exercise and calorie counting. Given the above, the request for 10-week [REDACTED] weight loss program is not medically necessary.

**One prescription of Ultram 50 mg # 60 with two refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, ongoing management, opioid dosing Page(s): 60.78.86.

**Decision rationale:** The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. There was a lack of documented rationale for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for 1 prescription of Ultram 50 mg #60 with 2 refills is not medically necessary.

**One prescription of Ibuprofen 800 mg # 90 with two refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The California MTUS guidelines indicate that NSAIDS are recommended for short term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for 1 prescription of ibuprofen 800 mg #90 with 2 refills is not medically necessary. There was a lack of documented rationale for 2 refills.

**One prescription of Gab/cyclo/keto/caps/menth/camp cream 10/4/10/0.0375/5/2%:** 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, Gabapentin, Topical Cyclobenzaprine, Ketoprofen, Salicylate Topicals Page(s): 111, 113, 112, 105.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicates that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended Gabapentin: Not recommended. There is no peer-reviewed literature to support use do not recommend the topical use of Cyclobenzaprine as a topical muscle relaxants as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended. Ketoprofen is not currently FDA approved for a topical application. Salicylate topicals are recommended. The clinical documentation submitted for review failed to provide documentation of a trial and failure of an antidepressant and anticonvulsant. There was a lack of documentation to support the necessity for the requested medication. The request as submitted failed to indicate the frequency, body part, and specific quantity of topical being requested. Given the above, the request for one prescription of Gab/cyclo/keto/caps/menth/camp cream 10/4/10/0.0375/5/2% is not medically necessary.

**One orthopedic re-evaluation within six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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

**Decision rationale:** The Official Disability Guidelines indicate the need for a clinical office visit with a health care provider is based on the injured worker's concerns, signs and symptoms, clinical stability, and physician judgment, as well as medications the injured worker is taking. The clinical documentation submitted for review failed to indicate the rationale for the request. Additionally, the specific orthopedist to be followed up with was not noted per the request. Given the above, the request for one orthopedic re-evaluation within six weeks is not medically necessary.