MAXIMUS Federal Services

Case Number:	CM15-0024281		
Date Assigned:	02/13/2015	Date of Injury:	07/22/2013
Decision Date:	05/22/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/09/2015

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, Arizona
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 62 year old male, who sustained an industrial injury on 7/22/2013. The mechanism of injury was twisting. He reported injury of the right foot, and knee. The injured worker was diagnosed as having bilateral osteoarthritis of the knees, right greater than left and severe tricompartmental arthritis of the right knee with effusion. Treatment to date has included medications, restrictive duties, and physical therapy. The request is for Ibuprofen 800mg, Prilosec, Gaba cream, Lidocaine cream, and Cyclobenzaprine cream. On 11/21/2014, he reported physical therapy and medications were not helpful. He complained of left knee pain. The treatment plan included: neoprene brace, Ibuprofen, Prilosec, Gaba cream, Lidocaine and Cyclobenzaprine cream, chiropractic treatment, and home stretching exercises.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg (unspecified quantity): Upheld

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

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 prior medications. However, it was documented that prior medications were of no objective functional benefit. The injured worker previously utilized anti-inflammatory medications. There was a lack of documentation of objective pain relief. The request as submitted failed to indicate the frequency and quantity for the requested medication. Given the above, the request for ibuprofen 800 mg (unspecified quantity) is not medically necessary.

Prilosec (unspecified quantity): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California MTUS guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to indicate the injured worker was at intermediate or high risk for gastrointestinal events, or had gastritis. The rationale was not provided. The request as submitted failed to indicate the frequency, strength, and quantity of medication being requested. Given the above, the request for Prilosec (unspecified quantity) is not medically necessary.

Gaba Cream (unspecified): 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 Page(s): 111,113.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety 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 is not recommended as there is no peer-reviewed literature to support use. The clinical documentation submitted for review failed to provide documentation of an exceptional factor to warrant nonadherence to guideline recommendations. The request for gaba cream failed to include the frequency, quantity, and specific body part to be treated. Additionally, there was a lack of

documentation indicating the injured worker had a trial and failure of antidepressants and anticonvulsants. Given the above, the request for gaba cream (unspecified) is not medically necessary.

Cyclobenzaprine Cream (unspecified): 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.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety 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. The topical use of Cyclobenzaprine as a topical muscle relaxants is not recommended 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. The clinical documentation submitted for review failed to provide documentation that an antidepressant and anticonvulsant had failed. There was a lack of documentation of exceptional factors as a topical muscle relaxant is not recommended. The request as submitted failed to indicate the frequency, quantity, and body part to be treated. Given the above, the request for cyclobenzaprine cream (unspecified) is not medically necessary.

Chiropractic treatment (unspecified quantity): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58, 59.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement a total of up to 18 visits over 6-8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle & foot, carpal tunnel syndrome, the forearm, wrist, & hand or the knee. The clinical documentation submitted for review indicated the injured worker's diagnosis included osteoarthritis. The manual therapy is not recommended for the treatment of the knee. The request as submitted failed to indicate the specific body part to be treated, as well as the quantity of sessions. Given the above, the request for chiropractic treatment (unspecified quantity) is not medically necessary.