MAXIMUS Federal Services

Case Number:	CM15-0041226		
Date Assigned:	04/09/2015	Date of Injury:	05/21/2012
Decision Date:	05/12/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	03/04/2015

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: New York
Certification(s)/Specialty: Emergency 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 25-year-old male, who sustained a fall with a twisting injury to his right knee on 5/21/12. The injured worker's diagnoses included bilateral knee patellofemoral osteoarthritis, status post right knee arthroscopy with partial lateral meniscectomy and planovalgus feet. On January 21, 2015, physical examination revealed decreased swelling and no crepitus in his right knee. The IW was described as minimally symptomatic to the right knee. Treatment to date has included right knee arthroscopy with partial lateral meniscectomy, Euflexxa injections, orthotics, physical therapy, home exercise program and anti-inflammatory oral medications. The IW requested an ice machine and a replacement set of orthotics. The provider ordered transdermal cream be applied 2-3 times a day, but did not discuss indications or intended area of use. The IW was released to full duty work with respect to his right knee. On February 2, 2015, UR denied requests for cold therapy unit, orthotics, and compound topical ointments. CA MTUS and ODG guidelines were cited in support of the decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy (polar care unit) for the right knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 - continuous flow cryotherapy.

Decision rationale: The MTUS does not provide direction for continuous flow cryotherapy. The Official Disability Guidelines this therapy for consideration of up to 7 days after surgery. The units are not recommended for non-surgical treatment. In this case, the unit is not being requested for the perioperative period. The unit is therefore not medically necessary.

Orthotics: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 370. Decision based on Non-MTUS Citation ODG - foot and ankle chapter.

Decision rationale: The primary reason for orthotics appears to be knee pain. The ACOEM Guidelines recommends orthotics only for plantar fasciitis and metatarsalgia. The Official Disability Guidelines has similar recommendations. The Official Disability Guidelines have a detailed list of recommendations for evaluation and treatment of pes planus, including a grading system and kinds of conservative and surgical care. There is no discussion regarding the use of orthotics to treat knee pain. The treatment plan is not consistent with the Official Disability Guidelines recommendations for pes planus, including the initial stages of conservative care contingent upon the grade of pes planus. The request is not support by the guidelines and are not medically necessary.

Retro: 10% Cyclebenzaprine 2% Lidocaine cream 30g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: CA MTUS chronic pain guidelines, topical analgesics are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines also state, "Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug that in not recommended is not recommended." One of the included compounds in the requested medication is baclofen. MTUS guidelines states that baclofen, a muscle relaxant, is not recommended. Additionally, the request does not include dosing frequency or duration. The request is not medically necessary.

Retro: 30g 20% Flurbiprofen 5% Lidocaine cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: CA MTUS chronic pain guidelines, topical analgesics are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines also state, "Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug that in not recommended is not recommended." One of the included compounds in the requested medication is Lidoderm cream is not indicated for non-neuropathic pain. There is nothing in the record that supports the diagnosis of neuropathic pain. For this IW, MTUS guidelines states that lidocaine is not recommended, as there is no peer-reviewed literature to support its use. Additionally, the request does not include dosing frequency or duration. The request is not medically necessary.

Retro: 30gm 10% Gabapentin 5% amitriptyline 0.025% capsaicin cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: CA MTUS chronic pain guidelines, topical analgesics are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines also state, "Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug that in not recommended is not recommended." One of the included compounds in the requested medication is Gabapentin. MTUS guidelines states that gabapentin is not recommended, as there is no peer-reviewed literature to support its use. Additionally, the request does not include dosing frequency or duration. The request is not medically necessary.