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| Case Number: | CM15-0087224 | | |
| Date Assigned: | 05/13/2015 | Date of Injury: | 12/10/2013 |
| Decision Date: | 09/15/2015 | UR Denial Date: | 04/08/2015 |
| Priority: | Standard | Application Received: | 05/06/2015 |

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 35-year-old male, who sustained an industrial injury on 12/10/2013. The initial complaints or symptoms included left knee pain/injury. The injured worker was diagnosed as having left knee strain/sprain. Treatment to date has included conservative care, medications, x-rays, MRIs, and conservative therapies. Currently, the injured worker complains of intermittent low back pain, and continued constant left knee pain with clicking, popping, and locking in the left knee. The diagnoses include left knee internal derangement/meniscus tear, lumbar spine musculoligamentous strain/sprain, rule out herniated nucleus pulposus, bilateral lower extremity radicular pain and paresthesia, and insomnia and GERD secondary to industrial injury. The request for authorization included the following denied services: cold therapy rental for 30 days, 24 sessions of post-op physical therapy, home health aide (no specified time), flurbiprofen 20% cream 120 gm, Ketoprofen 20%/ketamine 10% cream 120 gm, and Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0.0375% 120 gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy rental times 30 days: 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).

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

Decision rationale: Continuous flow cryotherapy is recommended as an option after surgery for rental, up to 7 days. Purchase is not recommended. There is no mention that the injured worker has been authorized for surgery, and rental of cold therapy units is recommended only for 7 days post-surgery. Medical necessity has not been medically necessary.

Post-op physical therapy times twenty four visits: 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).

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: According to the California MTUS Post-Surgical Guidelines, Post-operative physical therapy is recommended at 12 visits over 12 weeks status post meniscectomy or for internal derangement of the meniscus. The current request exceeds the guidelines, and there is no indicated that surgery has been authorized and/or performed. As such, this request is not medically necessary.

Home Health Aide-no specified amount of time requested: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: California Medical Treatment Utilization Chronic Pain Medical Treatment Guidelines (Page 51) address home health services. Home health services are recommended only for medical treatment for patients who are homebound. Home health services are recommended only for medical treatment. Medical treatment does not include homemaker services like shopping, or laundry. Medical treatment does not include personal care given by home health aides like bathing, dressing, and using the bathroom. Home health aides are not considered medical treatment and are not recommended. There is no clear rationale for the home health aide request, nor is there a specific amount of time requested. Without supportive documentation, this request cannot be medically necessary at this time.

Flurbiprofen 20% cream #120 gm: 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).

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

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. There is no clear rationale for this request. There is failure to demonstrate failure to first line oral anticonvulsant or antidepressants for pain. Medically necessity has not been substantiated. This request is not medically necessary.

Ketaprofen 20%/Ketamine 10% cream #120: Upheld

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

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

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. There is no clear rationale for this request. There is failure to demonstrate failure to first line oral anticonvulsant or antidepressants for pain. Medically necessity has not been substantiated. This request is not medically necessary.

Gabapentin 10%/Cyclbenzaprine 10%/Capsaicin 0.0375% #120: Upheld

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

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

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. There is no clear rationale for this request. There is failure to demonstrate failure

to first line oral anticonvulsant or antidepressants for pain. Medically necessity has not been substantiated. This request is not medically necessary.