

Case Number:	CM14-0128440		
Date Assigned:	09/26/2014	Date of Injury:	11/30/2007
Decision Date:	10/28/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/11/2014

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. The expert reviewer is Board Certified in Orthopedic and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 54-year-old female with a date of injury of November 30, 2007. The patient had left knee surgery and unicompartmental knee arthroplasty. The patient's date of surgery was May 19, 2014. The patient was transferred to a skilled nursing facility unable to walk. She reports having no one to help at home. The patient is having a lot of pain and swelling. She completed 12 sessions of postoperative physical therapy. She may progress in physical therapy. She's having difficulty negotiating stairs. Her range of motion is -3 203 and the knee. Motor strength is improving. The patient is continuing physical therapy. At issue is whether a raise shower seat is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shower Seat: 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) Knee and Leg Chapter

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 chapter,

Decision rationale: A raise shower seat is not medically necessary at this time the medical records do not document and establish home evaluation to determine the medical necessity for raise shower seat. There is no documentation that the patient is having difficulty with this seated in standing position. There is no documentation that indicate that the patient is unable to stand and using hand-held shower unit. Criteria for a raise shower seat not met. Therefore, Shower Seat is not medically necessary and appropriate.

Orphenadrine/Caffeine 50/ 10 MG # 60: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter

Decision rationale: Compounded Medicines remain experimental without significant peer review literature to support the use. This drug as similar to Benadryl and when combined with caffeine the mode of action is that clearly understood. The compound the drug is not FDA approved. The medical necessity of this drug in the exact medical reason for the use of this drug in this case has not been established in the medical records. Criteria for use not met. Therefore, Orphenadrine/Caffeine 50/ 10 MG # 60 is not medically necessary and appropriate.

Gabapentin/Pyridoxine 250 mg/10 mg # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Compound. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Compound Drugs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: This patient does not meet criteria for Gabapentin & piroxidine. Specifically, gabapentin is recommended for neuropathic pain. There is no documentation of neuropathic pain. Gabapentin is not appropriate for cases of chronic non neuropathic knee pain. Criteria not met. Therefore, Gabapentin/Pyridoxine 250 mg/10 mg # 60 is not medically necessary and appropriate.

Keratek analgesic gel, 4 oz, quantity 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Topical analgesics remain experimental for the treatment of chronic pain. Her primary recommended for neuropathic pain when trials of antidepressants have failed. There is no documentation a trial and failure of any depressions. Topical anesthetics not

medically necessary. There is little research to support the use of many the agents in these topical anesthetics. Therefore, Keratek analgesic gel, 4 oz, quantity 1 is not medically necessary and appropriate.

Fluribiprofen/Cyclo/Menth Cream 20%/10%/4% 180 gm, quantity 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Compound. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Compound Drugs

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG pain chapter

Decision rationale: There is little peer review literature support the use of topical anesthetics for chronic pain. In addition any compounder product that contains a base 1 drug that is not recommended is not recommended. Topical anesthetics are recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. In this case is no documentation a trial and failure of antidepressants or anticonvulsants. Therefore, Fluribiprofen/Cyclo/Menth Cream 20%/10%/4% 180 gm, quantity 1 is not medically necessary and appropriate.

Hydrocodone/APAP/Ondan 10/300/2mg #40: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter

Decision rationale: The medical records do not indicate that this patient is about a functional restoration program. The use of narcotic medication is not documented medical records to improve the patient's function. In addition the use of compounded medication is not recommended when 1 of the drugs is not recommended. Criteria for narcotic medication mixed with NSAID medication not met. Therefore, Hydrocodone/APAP/Ondan 10/300/2mg #40 is not medically necessary and appropriate.

Omeprazole 10 mg/Flurbiprofen 100 mg # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Compound. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Compound Drugs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter

Decision rationale: There is no documentation of this patient has previous GI disorder or GI diagnosis. There is also no documentation indicating that the patient had a previous first line

NSAID with failure of the first line NSAID medication. Criteria for this medication not met. Therefore, Omeprazole 10 mg/Flurbiprofen 100 mg # 60 is not medically necessary and appropriate.