MAXIMUS Federal Services

Case Number:	CM14-0137681		
Date Assigned:	10/13/2014	Date of Injury:	03/27/2006
Decision Date:	11/13/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/26/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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:

This is a patient with a date of injury of 3/27/06. A utilization review determination dated 7/25/14 recommends non-certification of ketoprofen cream, pain management consultation for ESI, knee brace, PT, chiropractic, and orthopedic surgeon consultation for left knee and shoulder. No medical reports from the requesting provider were submitted for review. The utilization review referenced a 6/3/14 medical report identifying headaches, radicular neck and back pain, and muscle spasms. The symptoms persist, but the medications offer temporary relief of pain and improve the ability to have restful sleep. On exam, there is tenderness, limited ROM, positive Neer's and Hawkins', and decreased sensation and strength in unspecified dermatomes/myotomes. It was noted that PT and chiropractic have been approved in the past on several occasions. Orthopedic consultation was noted to have been approved 1/10/14 and 5/14/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% cream 165 gm QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic; Ketoprofen Topical Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for ketoprofen cream, CA MTUS states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical ketoprofen is "not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested Ketoprofen cream is not medically necessary.

Pain Management Consultation re: Epidural Steroid Injections, Cervical & Lumbar spine QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: Regarding the request for pain management consultation for epidural steroid injections, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Within the documentation available for review, there are no recent subjective complaints or objective examination findings supporting a diagnosis of radiculopathy. Additionally, there are no imaging or electrodiagnostic studies corroborating the diagnosis of radiculopathy. In the absence of such documentation, the currently requested pain management consultation for epidural steroid injections is not medically necessary.

Knee brace, open patella with metal stays QTY: 1.00: Upheld

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

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

Decision rationale: Regarding the request for a knee brace, CA MTUS and ACOEM state that a brace can be used for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability, although its benefits may be more emotional than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. Within the documentation available for review, there is no indication that the patient has an indication

for which a knee brace is indicated as outlined above. In the absence of such documentation, the currently requested knee brace is not medically necessary.

Physical Therapy Treatments, for affected body parts QTY: 18.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Physical Medicine Page(s): 98-99.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend up to 10 sessions with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

Chiropractic Treatment, for affected body parts QTY: 18.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation for chronic pain Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: Regarding the request for chiropractic treatment, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is documentation of completion of prior chiropractic sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised chiropractic treatment. Furthermore, the request exceeds the amount of chiropractic recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested chiropractic treatment is not medically necessary.

Orthopedic surgeon Consultation for left knee and right shoulder QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7 page 127

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127

Decision rationale: Regarding the request for orthopedic surgeon consultation for left knee and right shoulder, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, there is no clear rationale provided for the requested consultation. Furthermore, it is noted that orthopedic consultation has been authorized multiple times in the past and there is no rationale for additional consultation. In light of the above issues, the currently requested orthopedic surgeon consultation for left knee and right shoulder is not medically necessary.