MAXIMUS Federal Services

Case Number:	CM14-0098077		
Date Assigned:	07/28/2014	Date of Injury:	12/07/2012
Decision Date:	10/01/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/26/2014

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 Family Medicine, and is licensed to practice in California, Florida, and Tenessee. 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 injured worker is a 61 year old female who reported injuries to numerous areas including her right knee, left wrist, left arm, and neck. The MRI of the right knee dated 03/06/13 indicated the injured worker had medial meniscal tear. The QME dated 05/06/13 indicated the initial injury occurred as a result of continually driving a school bus and van. The injured worker reported frequent bending, stooping, and twisting of the body in order to fully inspect each bus. The procedure note dated x-ray of the left knee dated 12/13/12 revealed moderate osteoarthritis. X-rays of the right knee also revealed moderate osteoarthritis. A clinical note dated 03/06/14 indicated the injured worker complaining of continual pain in knees. The injured worker used topical analgesics including Keratek gel. Electrodiagnostic studies on 04/28/14 revealed evidence of left median neuropathy sensory neuropathy at the wrists consistent with left sided mild carpal tunnel syndrome and moderate right sided carpal tunnel syndrome. The clinical note dated 05/05/14 indicated the injured worker complaining of low back pain. The injured worker rated her low back pain and bilateral knee pain 7/10. The utilization review dated 05/29/14 resulted in denials for MRI of the left wrist, physical therapy for the cervical spine, and compounded medications as no objective information was submitted regarding findings at the left wrist or cervical spine. Compounded medications were generally not recommended without supporting evidence of safety and efficacy.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the left wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and Hand Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

Decision rationale: The injured worker complained of findings consistent with carpal tunnel syndrome at both wrists. MRI of the wrist is indicated for injured workers who have findings consistent with infection. No information was submitted regarding infection status at the left wrist. Given this, the request for MRI is not indicated as medically necessary.

Physical Therapy 2X6, cervical spine, left arm: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Physical Medicine.

Decision rationale: Physical therapies for the total of 10 sessions of physical therapy are recommended for the cervical spine. However, no objective data was submitted confirming any functional deficits associated with the cervical spine. Given this, the request for Physical Therapy 2 times a week for 6 weeks for cervical spine and left arm is not medically necessary.

Kera-Tek gel: 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, Page(s): 111.

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, this compound (Kera-Tek gel) cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Flurbiprofen/Cyclobenzaprine/Menthol cream 180 gm: Upheld

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

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

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, this compound (Flurbiprofen/Cyclobenzaprine/Menthol cream) cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.