MAXIMUS Federal Services

Case Number:	CM14-0098229		
Date Assigned:	07/30/2014	Date of Injury:	11/09/2000
Decision Date:	09/19/2014	UR Denial Date:	06/20/2014
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 Occupational 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:

According to the records made available for review, this is a 70-year-old male with a 11/9/00 date of injury, and right total knee replacement on 10/3/11. At the time (6/11/14) of request for authorization for Right knee brace, Diclofenac Sodium 1.5% 60gm #2, Orphenadrine ER 100mg #90, and Ketamine 5% 60gr #1, there is documentation of subjective (back and bilateral knee pain) and objective (ambulates with cane, intact knee flexion/extension against resistance, and difficult to assess hip flexion/extension due to pain) findings, current diagnoses (pain in joint of lower leg and lumbar disc displacement without myelopathy), and treatment to date (medications (including Protonix, Flexeril, and ongoing treatment with Tylenol #4, Naproxen and Orphenadrine since at least 5/14/14) and topical creams (including ongoing treatment with diclofenac sodium 1.5% and ketamine 5% since at least 2/5/14)). Regarding Knee brace, there is no documentation of patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability; and abnormal limb contour; Skin changes, Severe osteoarthritis (grade III or IV), Maximal off-loading of painful or repaired knee compartment, or Severe instability. Regarding Diclofenac sodium 1.5%, there is no documentation of short-term (up to 12 weeks) treatment; failure of an oral NSAID or contraindications to oral NSAIDs; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Diclofenac sodium 1.5% use to date. Regarding Orphenadrine, there is no documentation of short-term (less than two weeks) treatment. Regarding Ketamine 5%, there is no documentation of neuropathic pain when trial of antidepressants and anticonvulsants have failed; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ketamine 5% use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee brace: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Knee braces.

Decision rationale: MTUS reference to ACOEM Guidelines identifies that a brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability; and that a brace is necessary only if the patient is going to be stressing the knee under load. In addition, MTUS identifies that braces need to be properly fitted and combined with a rehabilitation program. ODG identifies documentation of abnormal limb contour (such as: Valgus [knock-kneed] limb, Varus [bow-legged] limb, Tibial varum, Disproportionate thigh and calf (e.g., large thigh and small calf), or Minimal muscle mass on which to suspend a brace); Skin changes (such as: Excessive redundant soft skin, Thin skin with risk of breakdown (e.g., chronic steroid use), Severe osteoarthritis (grade III or IV), Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain), or Severe instability (as noted on physical examination of knee), as criteria necessary to support the medical necessity of knee braces. Within the medical information available for review, there is documentation of diagnoses of pain in joint of lower leg and lumbar disc displacement without myelopathy. In addition, there is documentation of conservative treatment. However, there is no documentation of patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability, abnormal limb contour (Valgus [knock-kneed] limb, Varus [bow-legged] limb, Tibial varum, Disproportionate thigh and calf (e.g., large thigh and small calf), or Minimal muscle mass on which to suspend a brace); Skin changes (Excessive redundant soft skin, Thin skin with risk of breakdown (e.g., chronic steroid use), Severe osteoarthritis (grade III or IV), Maximal off-loading of painful or repaired knee compartment, or Severe instability. Therefore, based on guidelines and a review of the evidence, the request for Right knee brace is not medically necessary.

Diclofenac Sodium 1.5% 60gm #2: 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 Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Official Disability Guidelines (ODG) Pain, Diclofenac sodium.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Diclofenac Sodium 1.5%. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs and used as second line treatment, as criteria necessary to support the medical necessity of Diclofenac Sodium Gel. Within the medical information available for review, there is documentation of diagnoses of pain in joint of lower leg and lumbar disc displacement without myelopathy. In addition, there is documentation of ongoing treatment with Diclofenac sodium 1.5% cream. Furthermore, there is documentation of osteoarthritis pain in joints that lend themselves to topical treatment (knee). Moreover, given documentation of ongoing treatment with NSAIDs, there is documentation of Diclofenac sodium use as second line treatment. However, given documentation of Diclofenac sodium use since at least 2/5/14, there is no documentation of short-term (up to 12 weeks) treatment. In addition, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Diclofenac sodium 1.5% use to date. Therefore, based on guidelines and a review of the evidence, the request for Diclofenac Sodium 1.5% 60gm #2 is not medically necessary.

Orphenadrine ER 100mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of pain in joint of lower leg and lumbar disc displacement without myelopathy. In addition, given documentation of ongoing treatment with opioids, there is documentation of Orphenadrine used as a second line agent. However, there is no documentation of acute muscle spasms or acute exacerbation of chronic low back pain. In addition, given a request of 90 tablets of Orphenadrine, there is no documentation of short-term (less than two weeks) treatment. Therefore, based on guidelines and a review of the evidence, the request for Retrospective request for Orphenadrine ER 100mg #90 is not medically necessary.

Ketamine 5% 60gr #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 117-119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when trial of antidepressants and anticonvulsants have failed, as criteria necessary to support the medical necessity of topical analgesics. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of pain in joint of lower leg and lumbar disc displacement without myelopathy. However, there is no documentation of neuropathic pain when trial of antidepressants and anticonvulsants have failed. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ketamine 5% use to date. Therefore, based on guidelines and a review of the evidence, the request for Ketamine 5% 60gr #1 is not medically necessary.