MAXIMUS Federal Services

Case Number:	CM14-0212363		
Date Assigned:	01/02/2015	Date of Injury:	03/08/2005
Decision Date:	02/28/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/18/2014

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. 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: Texas, Ohio, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 applicant is a represented [redacted] beneficiary who has filed a claim for chronic knee pain reportedly associated with an industrial injury of March 8, 2005.In a Utilization Review Report dated November 20, 2014, the claims administrator denied request for a Keratek gel, a diclofenac-lidocaine compound, a flurbiprofen-cyclobenzaprine-menthol compound, and a gabapentin-pyridoxine compound. In a separate Utilization Review Report of the same date, November 20, 2014, the claims administrator partially approved a request for one week of home health skilled nursing facility as two separate home health visits, partially approved request for postoperative continuous cooling unit as a one-week rental of the same, and partially approved a request for continuous passive motion device as a 17-day rental of the same, and partially approved request for one week of home health physical therapy as three visits of the same. The claims administrator referenced progress note of October 22, 2014 and an RFA form of November 11, 2014 in its determination. The applicant's attorney subsequently appealed. On October 22, 2014, the applicant reported severe knee pain. The applicant had undergone four arthroscopic knee surgeries. The applicant was off of work and remained disabled, the treating provider noted. The applicant reportedly had severe tricompartmental knee arthritis, radiographically confirmed. A total knee arthroplasty was sought. The applicant was given prescriptions for orphenadrine-caffeine, gabapentin-pyridoxine, oral omeprazole-flurbiprofen, hydrocodone-acetaminophen-ondansetron, and several topical compounds. Various other postoperative articles were endorsed. On September 11, 2014, the applicant was given various diagnoses, including knee arthritis, shoulder adhesive capsulitis status post shoulder surgery,

chronic low back pain status post lumbar fusion surgery, dyslipidemia, and acid reflux. The presence or absence of any active symptoms of reflux or dyspepsia was not stated, nor did the progress note in question contain any discussion of medication efficacy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin/Pyridoxine 250/10mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

Decision rationale: No, the gabapentin-pyridoxine compound/amalgam was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 11, page 264, vitamin B6 (AKA pyridoxine) is often used in carpal tunnel syndrome when it is perceived to be deficient, though this practice is not consistently supported by the medical evidence. Here, there was no mention of the applicant's carrying a diagnosis of laboratory-confirmed vitamin B6 (AKA pyridoxine) insufficiency. Since the pyridoxine (vitamin B6) component of the amalgam is not recommended, the entire amalgam is not recommended. Therefore, the request was not medically necessary.

Flurbiprofen/Cyclo/Menthol 20%/10%/4% cream quantity 180mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): (s) 111-113.

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

Decision rationale: Similarly, the flurbiprofen-cyclobenzaprine-menthol compound was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 113 of the MTUS Chronic Pain Medical Treatment Guidelines, muscle relaxants such as cyclobenzaprine are not recommended for topical compound formulation purposes. Since one or more ingredients in the compound are not recommended, the entire compound is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.

Keratek gel #4oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals and Functional Restoration Approach to Chronic Pain Management Page(s): 105;.

Decision rationale: The request for Keratek gel, a salicylate topical, was not medically necessary, medically appropriate, or indicated here. While page 105 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that salicylate topicals such as Keratek are recommended in the treatment of chronic pain as was/is present here, this recommendation is, however, qualified by commentary made on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that an attending provider should incorporate some discussion of medication efficacy into his choice of recommendations. Here, the applicant was/is off of work. The applicant was described as disabled, despite ongoing usage of Keratek. Ongoing usage of Keratek failed to curtail the applicant's dependence on numerous other oral pharmaceuticals and/or topical compounds. There was no mention of any quantifiable decrements in pain achieved as a result of ongoing Keratek usage. Therefore, the request was not medically necessary.

Diclofenac/Lidocaine 3%/5% quantity 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Pain Mechanism Page(s): 111-112; 3.

Decision rationale: Similarly, the diclofenac-lidocaine compound was likewise not medically necessary, medically appropriate, or indicated here. While page 112 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that topical lidocaine is indicated in the treatment of localized peripheral pain or neuropathic pain in applicants in whom there has been a trial and/or failure of first-line antidepressants and/or anticonvulsant adjuvant medications, in this case, however, the applicant's ongoing usage of gabapentin, an anticonvulsant adjuvant medication, effectively obviated the need for the lidocaine-containing compound. It is further noted that the applicant carries a diagnosis of knee arthritis, a condition not classically associated with neuropathic pain, which per page 3 of the MTUS Chronic Pain Medical Treatment Guidelines, is characterized by lancinating, burning, numbing, and electric shock like symptoms. Since the lidocaine component of the amalgam is not recommended, the entire amalgam is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.

Home health skilled nursing for one week; no quantity or frequency: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48,Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: The request for home health skilled nursing for one week without any quantity or frequency was not medically necessary, medically appropriate, or indicated here. While page 51 of the MTUS Chronic Pain Medical Treatment Guidelines does support home health services to provide otherwise recommended medical treatment in applicants who are homebound or bedbound, in this case, however, it was not clearly established that the applicant would necessarily be homebound or bedbound following the planned total knee arthroplasty procedure. It is further noted that the MTUS Guideline in ACOEM Chapter 3, page 48 stipulates that an attending provider furnish a prescription for physical therapy or physical methods which "clearly states treatment goals." Here, the request for open-ended home health skill nursing without any quantity or frequency, by definition, did not clearly state treatment goals, treatment quantity, or treatment frequency. Therefore, the request was not medically necessary.

Post-op cold therapy unit: 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, Continuous flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines ODG Knee Chapter, Continuous-flow Cryotherapy topic.

Decision rationale: Similarly, the proposed postoperative cold therapy unit [purchase] was not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. While ODG's Knee Chapter, Continuous-flow Cryotherapy topic does acknowledge that continuous-flow cryotherapy is recommended as an option for postoperative use purposes, for up to seven days. Here, however, the attending provider sought authorization for a purchase of the continuous-flow cryotherapy device. Such usage represents treatment well in excess of ODG parameters. The attending provider's progress note did not contain any compelling applicant-specific rationale which would offset the unfavorable ODG position on the article at issue. Therefore, the request was not medically necessary.

Post-op continuous passive motion for 21 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), Knee and Leg Chapter, CPM

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Third Edition, Knee Chapter, Continuous Passive Motion section.

Decision rationale: The request for postoperative continuous passive motion for 21 days was likewise not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. However, the Third Edition ACOEM Guidelines note that continuous passive motion is not recommended for routine use following total knee arthroplasty surgery but, rather,

should be reserved for select, substantially physically inactive applicants postoperatively. Here, the attending provider did not clearly state that the applicant was, in fact, substantially inactive postoperatively or preoperatively. No rationale for CPM was furnished in the face of the unfavorable ACOEM position on the same. Therefore, the request was not medically necessary.

Home health physical therapy for one week, no frequency or quantity: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48,Postsurgical Treatment Guidelines.

Decision rationale: Finally, the request for home health physical therapy for one week without any quantity or frequency was not medically necessary, medically appropriate, or indicated here. While the Postsurgical Treatment Guidelines in MTUS 9792.24.3 do endorse a general course of 24 sessions of treatment following total knee arthroplasty surgery as was apparently scheduled here, this recommendation is, however, qualified by qualified by commentary in ACOEM Chapter 3, page 48 to the effect that an attending provider should furnish a prescription for physical therapy and/or physical methods which "clearly state treatment goals." Here, the request for open-ended home health physical therapy without a treatment frequency or quantity, by definition, do not clearly state or clearly articulate treatment goals. Therefore, the request was not medically necessary.