MAXIMUS Federal Services

Case Number:	CM15-0014007		
Date Assigned:	02/02/2015	Date of Injury:	03/02/2005
Decision Date:	03/24/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/23/2015

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: New York, West Virginia, Pennsylvania
Certification(s)/Specialty: Emergency 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 injured worker is a 44 year old male patient, who sustained an industrial injury on 03/02/2005. A primary treating office visit dated 12/17/2014 reported subjective complaint of increased symptoms since last visit. He reported bilateral hand/wrist pain rated a 6 in intensity and accompanied with numbness and tingling. He also has complaint of low back and left knee pain. Objective findings showed left knee with popping, crepitus and locking; medical joint line tenderness and a positive McMurray's test. His lumbar spine noted with positive Braggard's on the left associated with peroneal spasm and sciatic notch on the left. he is diagnosed with status post left knee surgery 04/22/2014 with good resolution of symptom; degenerative disc disease, left lower extremity radiculopathy; rule out intracarpal ligament tear, bilateral wrists; and rule out bilateral carpal tunnel syndrome. The plan of care involved a follow up in 6 weeks with prescription for Motrin, and Prilosec. A request for a urine toxicology screen and a compound cream were made during this visit. On 12/24/2014 Utilization Review non-certified that request, noting the CA MTUS/ACOEM and Official Disability guidelines, Drug Screen, Topical Analgesia and NSAIDS were cited. The injured worker submitted an application for an independent medical review of services.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Urine Toxicology Screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opiates, steps to prevent misuse.

Decision rationale: Guidelines recommend drug testing to assess compliance with prescribed treatment and to screen for the presence of illegal drugs of abuse. Drug screening is indicated if there is evidence of high risk/aberrant behavior, history of substance abuse or if an increased dosage does not result in decreased pain and increased function. Frequency of random testing should be based on risk stratification with low risk candidates being tested on a yearly basis, those at moderate tested 2-3 times per year and those at high risk may be tested as often as once per month. Based on the records provided, the patient is not a candidate for urine drug screening. The patient is not taking opiates and the patient is considered low risk and had at least one urine drug screen on 11/5/2014.

1 Prescription of Flurbiprofen/Cyclo/Menthol 20%/10%/4% Cream #180gm: Upheld

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

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

Decision rationale: The guidelines state that any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Since the guidelines state that Flurbiprofen is not supported, the compounded medication is not supported. Furthermore there is no evidence that topical muscle relaxants or topical application of menthol are effective.

1 Prescription Of Keratek gel #4 oz: Upheld

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

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

Decision rationale: Topical analgesics are primarily recommended for neuropathic pain when antidepressant and anticonvulsant treatments have failed.There is little research to support the use of many of these agents.