MAXIMUS Federal Services

Case Number:	CM15-0174735		
Date Assigned:	09/16/2015	Date of Injury:	09/10/1998
Decision Date:	11/10/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/04/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 52 year old female, who sustained an industrial injury on September 10, 1998. The initial symptoms reported by the injured worker are unknown. The injured worker was diagnosed as having lumbago. Treatment to date has included brace, medication and diagnostic studies. On August 7, 2015, the injured worker complained of knee and backs symptoms. Her knee brace and lumbar spine brace were noted to be worn out. She was noted to be "trying to survive" on Ibuprofen and Volataren gel for her disc pathology in the lumbar spine. She was reported to have evidence for radiculitis. The treatment recommendations included Ibuprofen, Volataren gel, right knee brace, lumbar spine brace and a follow-up visit. On August 28, 2015, utilization review denied a request for one lumbar support brace, one right knee brace, Voltaren gel 1% and Ibuprofen 800mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

One lumbar support brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG0, Low Back-Lumbar & Thoracic (Acute & Chronic): Lumbar Supports 2015.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Activity. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports.

Decision rationale: Regarding the request for lumbar brace, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. ODG goes on to state that for nonspecific low back pain, compared to no lumbar support, elastic lumbar belt maybe more effective than no belt at improving pain at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, the evidence was very weak. Within the documentation available for review, it does not appear that this patient is in the acute or subacute phase of his treatment. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested lumbar brace is not medically necessary.

One right knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & chronic): Knee braces 2015.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Activity Alteration. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Knee brace.

Decision rationale: Regarding the request for a knee brace, ACOEM Practice Guidelines 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. Furthermore, the ODG state that prefabricated knee bracing (rather than custom) may be appropriate for knee instability, ligament insufficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental osteoarthritis, and tibial plateau fracture. Custom-fabricated knee braces may be appropriate for patients with abnormal limb contour (valgus or varus deformity), skin changes (ie, redundant soft skin, thin skin with risk of breakdown), severe osteoarthritis (grade III or IV), maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain), and severe instability as noted on physical examination of knee. Within the documentation available for review, there is no indication that the patient has any of the diagnoses for which a knee brace is indicated. In the absence of such documentation, the currently requested knee brace is not medically necessary.

Voltaren gel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Voltaren gel, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there is no indication that the patient has obtained any specific analgesic effect or specific objective functional improvement from the use of Voltaren gel. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, or that the voltaren is for short term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Voltaren gel is not medically necessary.

Ibuprofen 800mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steriodal anti-inflammatory drugs).

Decision rationale: Regarding the request for Motrin (ibuprofen), Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Motrin is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Motrin is not medically necessary.