

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/7/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	5/2/2005
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004365

- 1) MAXIMUS Federal Services, Inc. has determined the request for Ketoprofen rub **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Gabapentin cream **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Norco **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for interferential unit **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for hot and cold therapy unit **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for consultation with an orthopedic surgeon regarding possible left knee total arthroplasty **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/29/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for Ketoprofen rub **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Gabapentin cream **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Norco **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for interferential unit **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for hot and cold therapy unit **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for consultation with an orthopedic surgeon regarding possible left knee total arthroplasty **is medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The IMR application shows the employee was injured on 5/2/2005 and his representative disputes the 7/9/13 UR decision. The 7/10/13 UR letter from [REDACTED] shows a decision on 7/9/13 in response to the physician's 6/5/13 report. UR denied Ketoprofen rub, gabapentin cream, an IF unit, a consult with an orthopedic surgeon for left total knee arthroplasty (TKA), a hot/cold therapy unit and use of Norco. UR authorizes the UDS, but I am asked to review this. Dr [REDACTED] provided a report dated 6/5/13, the patient has low back and left knee pain. He had left knee patellectomy and was requested to see Dr [REDACTED] for left TKA. The exam shows lumbar spasms, straight leg raise on the left caused back pain, lower extremity muscle groups are 5/5. Dr [REDACTED] did an EMG/NCV (unlisted date) showing left L5/S1 radiculopathy. The plan was for ketoprofen rub, gabapentin cream, norco, UTS, IF unit, hot/cold therapy unit, and referral to see Dr [REDACTED] for possible TKA. The 5/7/13 report shows Norco is 4/day. The 3/20/13 report notes the patient improved overall, still with left knee pain. He had the stem cell injection to the left knee. There is a 10/3/12 report from Dr [REDACTED],

recommending Norco, stem cell injection to the left knee, and labs testosterone and PSA

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination from [REDACTED]
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Ketoprofen rub:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pg. 111-113 which is a part of Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines indicate the topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS does not recommend use of non-FDA approved agents and states Ketoprofen is not FDA approved for topical applications. It has an extremely high incidence of photocontact dermatitis. **The request for Ketoprofen rub is not medically necessary and appropriate.**

2) Regarding the request for Gabapentin cream:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pg. 111-113 which is a part of Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines indicate the topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS states topical gabapentin is not recommended. **The request for gabapentin is not medically necessary and appropriate.**

3) Regarding the request for Norco:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), pg. 88-89 which is a part of Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

MTUS does recommend Norco for pain, but for ongoing use, a satisfactory response is required. MTUS Guidelines also state pain should be discussed each visit and function on a numeric scale should be reported at least every 6 months. Furthermore, All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. There should be some indication that it reduces pain, or helps function or improves quality of life. In this case, the medical records provided for review do not indicate if there is an assessment of treatment efficacy for the Norco in past 6-months since the employee has been taking Norco (unspecified dose) for over 6 months. **The request for Norco is not medically necessary and appropriate.**

4) Regarding the request for interferential unit:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pg. 118-120 which is a part of Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The MTUS Guidelines state Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The MTUS criteria for a trial of interferential has not been met. There is no indication that the pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). **The request for Interferential Current Stimulation (ICS) is not medically necessary and appropriate.**

5) Regarding the request for hot and cold therapy unit:
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic), which is not a part of Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on ODG guidelines, Knee chapter, continuous flow cryotherapy, and ODG guidelines, Knee chapter, for Cold/heat packs.

Rationale for the Decision:

The Official Disability Guidelines recommend hot and cold packs for the knee, but if the physician is suggesting the continuous-flow hot and cold combination units, these would not be recommended. ODG states these are an option for 7 days post-op, but they are not recommended for nonsurgical treatment. The medical records submitted for review lack the documentation of a 'hot and cold therapy unit'. There is no description or rationale to support the request. **The request for hot and cold therapy unit is not medically necessary and appropriate.**

6) Regarding the request for consultation with an orthopedic surgeon regarding possible left knee total arthroplasty :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), Chapter 13 (Knee Complaints)(2004) pg. 343-4, which is a part of Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) pg. 127, 343 (Chapter 13), which is a part of MTUS.

Rationale for the Decision:

MTUS/ACOEM guidelines state a surgical consult is indicated if there was activity limitation for more than a month and if exercise programs did not increase range of motion or strengthen the area. The clinical notes, in this case, indicate the employee is a candidate for the surgical consult only. Furthermore, the guidelines state the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The medical records provided for review indicate the employee has activity limitation, lumbar spasms, and left knee pain. The clinical notes indicate the employee has improved overall, but still complains of left knee pain. **The request for consultation with an orthopedic surgeon regarding possible left knee total arthroplasty is medical necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/hs

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.