

Case Number:	CM14-0154415		
Date Assigned:	09/24/2014	Date of Injury:	07/24/2002
Decision Date:	11/05/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/22/2014

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 Physical Medicine & 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 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:

The injured worker is a 64-year-old female who reported an injury on 07/24/2002. The mechanism of injury was not provided. The diagnoses included major depressive disorder, insomnia, psychological factors affecting medical condition. The past medical treatment included medications. Surgical history was not provided. The diagnostic testing was not provided. The injured worker complained of forgets, fullness and sleeping an average of 5 to 6 hours per night. Physical examination revealed the injured worker has been taking the same medications for a few years. Medications included Lexapro, Klonopin, Restoril, and Atarax. The treatment plan is for a right knee brace, ibuprofen 10% #60 apply a thin layer to affected area. The rationale for the request was not provided. The Request for Authorization form was not submitted.

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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Walking Aids, Braces and Splints for Musculoskeletal Conditions, Daniel J. Van Durme, MD, Florida State University College of Medicine, Am Fam Physician 2007 Feb 1;75(3):342-348, The Use of Knee Braces, American Academy of Orthopaedic Surgeons, Accessed June 16, 2006

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340.

Decision rationale: The California MTUS/ACOEM guidelines state 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. In addition the guidelines state for the average patient, using a brace is usually unnecessary. The documents reviewed failed to indicate the injured worker experiences difficulty with prolonged standing and walking, stooping, squatting, kneeling or crawling or repetitive movement. There is lack of documentation that the injured worker would benefit from a knee brace at this time due to the functional deficit. The requesting physician's rationale for the request is not indicated within the provided documentation. Therefore the request for the left knee brace is not medically necessary.

Ibuprofen 10% #60, apply a thin layer to affected area: Upheld

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

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

Decision rationale: The California (MTUS) Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy and safety. The guidelines also state that any compound product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines recommend the use of Lidocaine for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder and use with neuropathic pain is not recommended as there is no evidence to support use. There is lack of documentation the injured worker has been treated with first line therapy. There is no indication that the injured worker has a diagnosis of osteoarthritis or tendinitis to a joint amenable to topical treatment. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. Given the above, the request for Ibuprofen 10% #60 apply a thin layer to affected area is not medically necessary.