

Case Number:	CM13-0030727		
Date Assigned:	11/27/2013	Date of Injury:	06/13/2008
Decision Date:	03/24/2014	UR Denial Date:	09/06/2013
Priority:	Standard	Application Received:	09/30/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and is licensed to practice in Florida. 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 physician 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 patient is a 61-year-old male who reported an injury on 06/13/2008 due to repetitive trauma that reportedly caused injury to the patient's cervical spine, bilateral shoulders, and bilateral knees. The patient's most recent clinical documentation provided objective findings to include tenderness to palpation over the cervical spine with limited range of motion, a positive shoulder compression test, and a positive cervical spine compression test. The patient also underwent a range of motion inclinometry test that revealed the patient had significantly restricted range of motion in the bilateral knees. It was noted that the patient's left knee range of motion was described as 0 degrees in extension and 38 degrees in flexion and the right knee range of motion was described as 0 degrees in extension and 35 degrees in flexion. The patient diagnoses included right knee status post scope on 10/08/2008, left knee sprain/strain, cervical spine strain/sprain. The patient's treatment plan included continued physical therapy, electrodiagnostic studies, an internal medicine evaluation for surgical clearance, continuous of medications, and a total knee arthroplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

internal medicine surgical clearance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative Lab Testing, Pre-operative EKG

Decision rationale: The requested internal medicine for surgical clearance is not medically necessary or appropriate. Official Disability Guidelines do recommend preoperative lab testing and a preoperative EKG when there is a planned surgery that involves implantation of hardware. However, the clinical documentation submitted for review does not support the need for surgical intervention at this time. Therefore, the need for an internal medicine surgical clearance is not medically necessary or appropriate

right total knee arthroplasty:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Total Knee Replacement.

Decision rationale: The requested right total knee arthroplasty is not medically necessary or appropriate. Official Disability Guidelines recommend total knee arthroplasty when there is evidence of severe osteoarthritis in more than 1 compartment that significantly impairs the patient's activities of daily living and is supported by an imaging study. The clinical documentation submitted for review does provide evidence that the patient has significantly limited range of motion. However, there is no documentation of an imaging study to support that the patient has severe multicompartament osteoarthritis. Additionally, the recent physical evaluation provided by the prescribing physician did not include an evaluation of the right knee. Therefore, it cannot be established if the patient's activities of daily living are significantly impaired by the patient's functional deficits. Additionally, Official Disability Guidelines recommend that all lesser treatments be exhausted prior to a total knee arthroplasty. The clinical documentation does indicate that the patient has participated in physical therapy. However, there is no documentation that the patient has had any type of injection therapy. As such, the requested right total knee arthroplasty is not medically necessary or appropriate.

physiotherapy 2-3 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested physiotherapy 2 to 3 times a week for 6 weeks is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of physical medicine to treat patients with significantly limited range of

motion and significant pain complaints. However, California Medical Treatment Utilization Schedule recommends that continuation of physical therapy be based on documentation of significant functional benefit. The clinical documentation submitted for review does not provide any evidence that the patient has had significant functional benefit from the prior therapy. Additionally, California Medical Treatment Utilization Schedule recommends that patients be transitioned into a home exercise program to maintain improvements obtained during skilled physical therapy. The clinical documentation submitted for review does not provide any evidence that the patient is participating in a home exercise program. Therefore, 1 to 2 visits would be appropriate to reassess and re-educate the patient in a home exercise program. However, the requested 2 to 3 times a week for 6 weeks is considered excessive. As such, the requested physiotherapy 2 to 3 times a week for 6 weeks is not medically necessary or appropriate.

home health assistance 4 hours a day 1-3 days per week: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: The requested home health assistance for 4 hours a day 1 to 3 days per week is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends home health assistance when a patient is home-bound on a part time or intermittent basis. The clinical documentation submitted for review does not provide any evidence that the patient is home-bound on either a part-time or intermittent basis. Therefore, the need for in home assistance is not indicated. As such, the requested home health assistance 4 hours a day 1 to 3 days per week is not medically necessary or appropriate.

Omeprazole 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested omeprazole 20 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends a gastrointestinal protectant for patients who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal disturbances related to medication usage. Therefore, the need for gastrointestinal protectant is not indicated. As such, the requested omeprazole 20 mg is not medically necessary or appropriate.

Tramadol 150mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Tramadol 150 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that opioids, when used in the management of chronic pain, be supported by a quantitative system of pain relief, documentation of functional benefit, managed side effects, and evidence of compliance to the prescribed medication schedule. The clinical documentation submitted for review does not provide any evidence of a quantitative assessment of pain relief as it is related to this medication. Additionally, there is no documentation of functional benefit related to medication usage. Also, there is no documentation that the patient is monitored on a regular basis for aberrant behavior. Therefore, continued use of this medication would not be indicated. As such, the requested Tramadol 150 mg is not medically necessary or appropriate.

Cyclobenzaprine 7.5mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested cyclobenzaprine 7.5 mg is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that this is a renewal of a previous prescription. This would support that the patient has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants for long durations of treatment. As the patient have the potential for duration of use that exceeds guideline recommendations, an additional prescription would not be indicated. As such, the requested cyclobenzaprine 7.5 mg is not medically necessary or appropriate.

Naproxen sodium 550mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Antidepressants for chronic pain Page(s): 60, 13.

Decision rationale: The requested naproxen sodium 550 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the continued use

of medications be supported by documentation of functional benefit and an assessment of pain relief. The clinical documentation submitted for review does not provide any evidence that the patient has any pain relief or functional benefit from medication usage. Therefore, continued use would not be indicated. As such, the requested naproxen sodium 550 mg is not medically necessary or appropriate.