

<b>Case Number:</b>	CM13-0043881		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/02/2009
<b>Decision Date:</b>	03/06/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 46-year-old female who reported an injury on 06/02/2009. The patient is currently diagnosed with status post partial medial meniscectomy and lateral meniscectomy of the left knee, right knee medial meniscal tear, lumbar sprain with degenerative joint disease, cervical sprain, anxiety and depression, insomnia, gastroesophageal reflux disease (GERD), obesity, status post repeat subtotal medial meniscectomy on the left knee, and status post lumbar and cervical epidural injections. The patient was seen by [REDACTED] on 08/28/2013. The patient reported 10/10 neck pain, 6/10 low back pain, 6/10 right knee pain, and 9/10 left knee pain. Physical examination revealed tenderness to palpation of the lateral joint line with normal range of motion. Treatment recommendations included physical therapy twice per week for 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the left knee, three (3) times a week for six (6) weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Physical Medicine Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine, page 98-99 Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Physical Therapy

**Decision rationale:** The Chronic Pain Guidelines indicate that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines allow for fading of treatment frequency plus active self-directed home physical medicine. As per the documentation submitted, the patient's physical examination on the requesting date of 08/28/2013 only revealed tenderness to palpation with normal range of motion. There was no documentation of a significant musculoskeletal or neurological deficit that would require skilled physical medicine treatment. Therefore, the request is non-certified.

**Tramadol ER 150mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 78, 93-94, and 113 Page(s): 78, 93-94, and 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, pages 74-82 Page(s): 74-82.

**Decision rationale:** The Chronic Pain Guidelines indicate that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no change in the patient's physical examination. Based on the clinical information received, the request is non-certified.

**Prilosec 20mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk, pages 68-69 Page(s): 68-69.

**Decision rationale:** The Chronic Pain Guidelines indicate that proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of proton pump inhibitors, even in addition to a non-selective non-steroidal anti-inflammatory drug (NSAID). There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.

**Flexeril 7.5mg, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 41, 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), page 63-66 Page(s): 63-66.

**Decision rationale:** The Chronic Pain Guidelines indicate that muscle relaxants are recommended as non-sedating second line options for short term treatment. Cyclobenzaprine (Flexeril) should not be used for longer than two to three (2-3) weeks. There is no documentation of palpable muscle spasm, spasticity, or muscle tension upon physical examination. As guidelines do not recommend long term use of this medication, the current request is non-certified.

**Ketoprofen topical cream:** Upheld

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

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

**Decision rationale:** The Chronic Pain Guidelines indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The only FDA approved topical non-steroidal anti-inflammatory drug (NSAID) is diclofenac. Gabapentin is not recommended as there is no peer reviewed literature to support its use. There is no documentation of neuropathic pain upon physical examination. There is also no indication of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. Based on the clinical information received, the request is non-certified.

**Gabapentin topical cream:** Upheld

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

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

**Decision rationale:** The Chronic Pain Guidelines indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The only FDA approved topical non-steroidal anti-inflammatory drug (NSAID) is diclofenac. Gabapentin is not recommended as there is no peer reviewed literature to support its use. There is no documentation of neuropathic pain upon physical examination. There is also no indication of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. Based on the clinical information received, the request is non-certified.

**Tramadol topical cream:** Upheld

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

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

**Decision rationale:** The Chronic Pain Guidelines indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The only FDA approved topical non-steroidal anti-inflammatory drug (NSAID) is diclofenac. Gabapentin is not recommended as there is no peer reviewed literature to support its use. There is no documentation of neuropathic pain upon physical examination. There is also no indication of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. Based on the clinical information received, the request is non-certified.

**Cortisone injection to the neck times two (2): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections, page 122 Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee, Cortisone injections

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, Steroids, Chronic Pain Chapter, and Trigger point injections

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that invasive techniques, such as injections have no proven benefit in treating acute neck and upper back symptoms. As per the documentation submitted, there was no indication of a significant musculoskeletal or neurological deficit with regard to the cervical spine. There was no evidence of myofascial pain or trigger points. It is noted on 08/28/2013, the patient was requesting a neck injection for a flare-up of 10/10 pain. There is also no indication of a failure to respond to recent conservative treatment prior to the request for injection therapy. Based on the clinical information received, the request is non-certified.