MAXIMUS Federal Services

| Case Number: | CM14-0008054 | | |
|---|---|---|---|
| Date Assigned: | 02/07/2014 | Date of Injury: | 09/06/2001 |
| Decision Date: | 07/17/2014 | UR Denial Date: | 12/19/2013 |
| Priority: | Standard | Application Received: | 01/21/2014 |

## 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 Orthopaedic Surgery and is licensed to practice in Mississippi. 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 57-year-old female who was injured on September 6, 2001. The mechanism of injury was not listed in the records reviewed. The most recent progress note dated January 14, 2014, indicated there were ongoing complaints of bilateral wrist pain, bilateral knee pain and low back pain. The physical examination demonstrated tenderness at the bilateral hands and wrists and a positive Tinel's test. There was normal risk range of motion. Examination of the lumbar spine noted paravertebral tenderness. Examination of the right knee noted crepitus and swelling as well as weakness. Range of motion of the left knee was noted to be 0 to 100. There were diagnoses of obesity, carpal tunnel syndrome, right knee chondromalacia, status post right knee surgery, cervical sprain, lumbar sprain, status post left knee total arthroplasty, trigger finger of the ring and long fingers left worse than the right hand. Current medications were stated to include tramadol, tizanidine and gabapentin. A cane and bilateral wrist splints were prescribed as well as a new right knee brace. AppTrim-D was prescribed for weight control, and acupuncture for the lumbar spine was recommended. A request was made for a right knee total arthroplasty, Restone, tramadol, hydrocodone, tizanidine, aquatic therapy, acupuncture, Duricef, Zofran, and a left sided long finger and ring finger trigger release which was not certified in the pre-authorization process on December 19, 2013.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**RESTONE 3/100MG (#30):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation website: howdrugs.com.

**Decision rationale:** Restone is a medication consisting of melatonin and tryptophan and is intended for use as a sleep aid. The medical record contains no information regarding the injured employee's difficulty sleeping or its relationship to the compensable injury. Therefore, the request is not medically necessary.

**TRAMADOL ER 150MG (#60):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48. Decision based on Non-MTUS Citation ODG, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 76 OF 127.

**Decision rationale:** Tramadol is an opioid pain medication indicated for short-term use of moderate to severe pain. It is not intended for chronic long-term usage. Continued use of tramadol should be justified by objective documentation of pain relief, ability to return to work, ability to perform activities of daily living, as well as absence of side effects and aberrent behavior. The documentation does not contain information regarding these issues. Therefore, the request is not medically necessary.

**HYDROCODONE/APAP 10/325 MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48. Decision based on Non-MTUS Citation ODG, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 76 OF 127.

**Decision rationale:** Hydrocodone is an opioid pain medication indicated for short-term use of moderate to severe pain. It is not intended for chronic long-term usage. Continued use of hydrocodone should be justified by objective documentation of pain relief, ability to return to work, ability to perform activities of daily living, as well as absence of side effects and aberrent behavior. The documentation does not contain information regarding these issues. Therefore, the request is not medically necessary.

**TIZANIDINE 4MG (#120):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63. Decision based on Non-MTUS Citation ODG, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS FOR PAIN Page(s): 63 OF 127.

**Decision rationale:** Tizanidine is a muscle relaxant and indicated as a short-term treatment option for acute exacerbations of chronic low back pain. While the injured employee may very well have episodes of acute exacerbations of her low back pain, this is a prescription is for 120 tablets, which does not indicate short-term episodic usage. Therefore, the request is not medically necessary.

**EIGHT (8) SESSIONS OF AQUATIC THERAPY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Pain, Suffering and the Restoration of Function Chapter, page 114; and the ODG, Physical Therapy Guidelines, Knee & Leg and Low Back Chapters.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY Page(s): 22.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend that aquatic therapy could be used as an option for land-based therapy when the benefit of reduced weight-bearing could be beneficial. It is assumed that this request is for the injured employee's knee pain, although that is not specified. Additionally, an aquatic therapy program should be monitored by the healthcare professional and that is also not specified. Additionally, considering the prior knee surgeries the injured employee has participated in, the individual should be well-versed in what is expected of physical therapy for the knees and could very well continue that program in a home-based exercise regimen. Therefore, the request is not medically necessary.

**EIGHT (8) SESSIONS OF ACUPUNCTURE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ACUPUNCTURE Page(s): 13 OF 127.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines specifies that acupuncture could be used as an option when pain medication is reduced or not tolerated and in conjunction with another functional recovery program. The documentation does not state that the injured employee has reduced or not tolerated any medications. Therefore, the request is not medically necessary.

**DURACEF:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guidelines Clearinghouse.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation website drugs.com.

**Decision rationale:** Duricef is an antibiotic medication. The documentation does not state the intention of using this medication. It may be used in the preoperative and postoperative setting, although this is not specified. Therefore, the request is not medically necessary.

**RIGHT TOTAL KNEE ARTHROPLASTY SURGERY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee and Leg Chapter, Indications for Surgery - Knee arthroplasty.

**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, TOTAL KNEE ARTHROPLASTY, UPDATED JUNE 10, 2014.

**Decision rationale:** According to the Official Disability Guidelines, a total knee arthroplasty surgery is not recommended for an individual over a body mass index of 35. The injured employee has a body mass index of 56.1, which would likely result in a failure of the surgery. Therefore, the request is not medically necessary.

**ZOFRAN:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter and the Physician's Desk Reference on drugs.com.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, LONG-TERM ASSESSMENT Page(s): 88 OF 127.

**Decision rationale:** Zofran is an antiemetic medication typically used to treat nausea and vomiting in the postoperative setting or for side effects of opioid medications. As knee surgery was determined to not be medically necessary, this request for Zofran is not medically necessary.

**LONG AND RING FINGER TRIGGER RELEASE SURGERY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): table 11-7. Decision based on Non-MTUS Citation ODG, Forearm, Wrist and Hand Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): table 11 - 7.

**Decision rationale:** According to the American College of Occupational and Environmental Medicine Surgery, trigger finger release is not recommended unless prior conservative treatments have been tried and have failed. There is no documentation that previous conservative treatment has been rendered with the use of steroid injections. This information must be documented prior to requesting the trigger finger release. Therefore, the request is not medically necessary.