

Case Number:	CM14-0104533		
Date Assigned:	07/30/2014	Date of Injury:	01/31/2003
Decision Date:	08/29/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/07/2014

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 70-year-old female with a reported date of injury on 01/31/2003. The mechanism of injury was a fall. The worker injured her back and her knee, and her shoulder. The injured worker's diagnoses consisted of a left and right total knee arthroscopy, right foot bursitis, colostomy, and perforation of intestines. The injured worker has had previous left and right knee arthroscopic surgery. Prior treatments included aquatic therapy, occupational therapy, and physical therapy throughout the years. The injured worker had an examination on 06/09/2014 for complaints of increased left knee pain. She reported that her bilateral knee pain and stiffness were increased since the prior visit. The injured worker walked with a walker. Upon examination, her left knee range of motion was restricted with flexion limited to 100 degrees due to pain and extension limited to 25 degrees due to pain. There was tenderness noted to palpation over the patella. Her medication list consisted of Ultram, Protonix, Fentanyl patch, and Celebrex. The plan of treatment was for physical therapy 2 times a week for 6 weeks and for an electric power chair and to renew her medications. The request for authorization was not provided and the rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Right and Left Knee 1-2 times for 4-6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83, Chronic Pain Treatment Guidelines Physical Therapy and Physical Medicine Page(s): 103.

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

Decision rationale: The California MTUS Guidelines note 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 help alleviate discomfort. Injured workers are usually instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The California MTUS Guidelines recommend up to 10 visits. There is a lack of documentation to demonstrate the injured worker has current significant functional deficits. There is a lack of documentation indicating whether the injured worker has previously completed any physical therapy as well as the efficacy of the prior therapy. The requesting physician did not provide an adequate and complete assessment of the injured worker's current objective functional condition. Furthermore, the request for 12 visits would exceed the guideline recommendations. Therefore, the request for Physical Therapy Right and Left Knee 1-2 times for 4-6 weeks is not medically necessary and appropriate.

Flector Patch 1.3%: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain.

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

Decision rationale: The California MTUS guidelines recommend the use of Non-Steroid Anti-Inflammatory Drugs (NSAIDs) for osteoarthritis and tendonitis, in particular 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. There is no indication that the injured worker has a diagnosis of osteoarthritis or tendonitis. Additionally, the request does not indicate the frequency at which the medication is prescribed, the site at which it is to be applied, or the quantity of the patches being requested in order to determine the necessity of the medication. Therefore, the request for Flector Patch 1.3% is not medically necessary and appropriate.

Voltaren gel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 117-119. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The California MTUS guidelines recommend the use of Non-Steroid Anti-Inflammatory Drugs (NSAIDs) for osteoarthritis and tendonitis, in particular 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. There is no indication that the injured worker has a diagnosis of osteoarthritis or tendonitis. Additionally, the request does not indicate the frequency at which the medication is prescribed, the site at which it is to be applied, or the quantity of the patches being requested in order to determine the necessity of the medication. Therefore, the request for Voltaren gel 1% is not medically necessary and appropriate.