MAXIMUS Federal Services

Case Number:	CM14-0010572		
Date Assigned:	02/21/2014	Date of Injury:	04/08/2011
Decision Date:	06/25/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/27/2014

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 patient is a 57 year old female who was injured on 04/08/2011 when she fell after tripping over a cord. Prior treatment history has included a PT report dated 10/18/2013 which indicates the patient has had physical therapy in the past with minimal help. The patient states that her goals for physical therapy are to decrease her bilateral knee pain. PR-2 dated 02/19/2014 documented the patient with complaints of continued pain in the left wrist, right shoulder and knees. She plans to attend approved physical therapy. She has been using Tylenol, Aleve and diclofenac. She notices a decrease in strength of left hand. Objective findings on exam reveal she is tender to palpation in upper extremities. Left shoulder strength 2/5, 50% of ROM. Right shoulder limited ROM to 75%. Knees are tender to touch in the medial aspects, right greater than left with positive cracking and click bilaterally. Diagnoses: 1. Primary osteoarthritis lower leg 2. Secondary osteoarthritis lower leg 3. Calcifying tendinitis of shoulder Treatment Plan: 1. Begin Celebrex 200 mg. 2. PT for upper body, 4 sessions as approved prior to increase strength. UR report dated 12/26/2013 denied the request for Voltaren Gel 1% 100 mg #10 as the medication is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee and wrist). It has not been evaluated for the treatment of the spine, hip or shoulder. The request for 12 physical therapy sessions was denied as the medical records do not clearly establish objective and measured functional gains, improvement with activities of daily living, or discussions regarding return to work as a result of previous physical therapy. In addition, the proposed number of visits in addition to the number of visits already completed would exceed guideline recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

VOLTAREN GEL 1% 100 GM #10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, VOLTAREN GEL 1% (DICLOFENAC), 112

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

Decision rationale: As per CA MTUS, Voltaren (non-steroidal anti-inflammatory drug NSAID) as topical analgesic is recommended for short term use (4-12 weeks) fir patients with Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. The medical records do not document a diagnostic imaging as an evidence of Osteoarthritis. Therefore, the medical necessity of Voltaren gel 1% 100GM #10 has not been established according to the guidelines.

TWELVE PHYSICAL THERAPY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE, 98-99

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

Decision rationale: As per CA MTUS guidelines, physical medicine 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. As per ODG guidelines, Physical Therapy (PT) is recommended for chronic knee pain. PT is recommended as 9 visits over 8 weeks for Osteoarthritis. The available medical records do not document any diagnostic evidence for the diagnosis of Osteoarthritis. On the other hand, the medical report dated 10/18/2013 indicates that the patient has had PT in the past with minimal benefit. The same report addresses that the patient states her goals for PT are to decrease her bilateral knee pain. The records lack detailed pain and functional assessment to support any indication of more PT visits. Therefore, the requested 12 Physical therapy visits is not medically necessary according to the guidelines.