

Case Number:	CM14-0016136		
Date Assigned:	06/04/2014	Date of Injury:	02/27/2001
Decision Date:	10/17/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/07/2014

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 Orthopedic Surgery, has a subspecialty in Orthopedic Sports Medicine and is licensed to practice in Maryland. 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 58-year-old female injured on 02/27/01 due to an undisclosed mechanism of injury. Current diagnoses include cervical disc syndrome, status post bilateral total knee replacement, status post left knee replacement, and chronic pain syndrome. Prior surgical history includes bilateral knee replacement, abdominal hysterectomy, right shoulder surgery, and lumbar and cervical spine surgery. Previous treatments include physical therapy, bilateral knee injections, cervical and thoracic epidural steroid injections, and medication management. The injured worker underwent total arthroplasty on 11/08/2013 with postoperative diagnoses to include hyperlipidemia, hypertension, in some man, gastroesophageal reflux disease, and anemia. Documentation indicates the injured worker was to be discharged to home environment with home health care for dressing change and subcutaneous Lovenox 40 mg times seven days. The injured worker was also intended to work with physical therapy in the home environment. The number of physical therapy sessions was not specified in the documentation. Medications as of 11/12/13 included Senna 8.6 mg b.i.d., Colace 100 mg b.i.d., vitamin C 500 mg QD, iron, atenolol 50 mg QD, Lovenox 40 mg QD, and Protonix 40 mg QD. The clinical note dated 11/18/13 indicated the injured worker presented with complaints of bilateral knee pain status post total left knee replacement. Physical examination revealed mild discoloration on the medial aspect of the left knee with mild effusion noted. Postoperative physical therapy with low-level work conditioning times 12 sessions was requested at the time. The initial request for physical therapy three times a week for eight weeks quantity 24, Tramadol ER 150 mg #30, Prilosec (Omeprazole) 20 mg #60, refill of Norco (Hydrocodone/APAP) 10/325 mg #60, topical analgesics - TG Hot cream 180 mg, and FlurFlex cream 180 mg was initially non-certified on 1/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3 Times a Week For 8 Weeks QTY: 24: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

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

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 24 visits over 10 weeks for the treatment of knee arthroplasty and allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. The clinical note indicated the injured worker received both home health guided physical therapy (number not specified) in addition to 12 sessions of out injured worker physical therapy. There is no documentation of exceptional factors that would support the need for therapy that exceeds guidelines either in duration of treatment or number of visits. The medical necessity of the physical therapy 3 times a week for 8 weeks QTY: 24 cannot be established at this time.

Tramadol ER 150MG, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 93-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. There is no discussion in the documentation regarding the use of Tramadol. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Tramadol ER 150MG, #30 cannot be established at this time.

Prilosec (Omeprazole) 20MG, #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors

Decision rationale: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The documentation indicates the injured worker has a history of GERD indicating the need for proton pump inhibitors. As such, the request for Prilosec (Omeprazole) 20MG, #60 is established as medically necessary.

Refill Of Norco (Hydrocodone/APAP), 10/325MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. There is no discussion in the documentation regarding the use of Tramadol. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of refill of Norco (Hydrocodone/APAP), 10/325MG #60 cannot be established at this time.

TG Hot Cream 180mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, the California MTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore TG Hot cream

180MG cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Flurflex Cream 180MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, the California MTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore Flurflex cream 180MG cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.