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| Case Number: | CM14-0018589 | | |
| Date Assigned: | 04/18/2014 | Date of Injury: | 01/22/2010 |
| Decision Date: | 06/30/2014 | UR Denial Date: | 01/30/2014 |
| Priority: | Standard | Application Received: | 02/13/2014 |

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 and Rehabilitation, has a subspecialty in Neuromuscular 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 patient is a 57-year-old female with a date of work injury 1/22/10. She presents with complaints of lumbar spine pain, cervical spine pain, and bilateral knee pain. Her diagnoses include cervical and lumbar spine sprain, cervical and lumbar annular tear with disc protrusions, lumbar radiculopathy, shoulder sprain on the right, bilateral knee sprain. There are requests for physical therapy two times a week for three weeks for the bilateral knees, cervical spine, lumbar spine; acupuncture two times a week for three weeks for the bilateral knees, cervical spine, lumbar spine; internal medicine consultation, Norco; Cyclo-Keto-Lido. Her surgeries in the past include bilateral carpal tunnel release in 2003, left knee arthroscopy in June 2010; right ulnar nerve transposition in 2011. A 1/28/14 pain management office visit states that the patient states that she is doing worse. She has completed physical therapy. She cannot participate in ADLs since her injury. She complains of bilateral knee pain, right shoulder, neck pain, stomachaches and mid back pain. She has medical issues of diabetes mellitus, hypertension, gastritis and insomnia. On physical exam, she has decreased cervical and lumbar range of motion and paraspinal tenderness. She has acromioclavicular tenderness and decreased right shoulder range of motion. She has knee parapatellar tenderness and decreased range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWO TIMES A WEEK FOR THREE WEEKS FOR THE BILATERAL KNEES, CERVICAL SPINE, LUMBAR SPINE: Upheld

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

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

Decision rationale: Physical therapy two times a week for three weeks for the bilateral knees, cervical spine, and lumbar spine is not medically necessary per the MTUS guidelines. The patient had an injury in 2010 and documentation indicates that she has had physical therapy. It is unclear how much therapy the patient has had and objective functional improvement and efficacy from prior physical therapy sessions. The patient continues to have significant pain and is not working. Without objective documentation of past therapy and functional improvement continued physical therapy cannot be certified. Therefore, the request for physical therapy two times a week for three weeks for the bilateral knees, cervical spine, and lumbar spine is not medically necessary.

ACUPUNCTURE TWO TIMES A WEEK FOR THREE WEEKS FOR THE BILATERAL KNEES, CERVICAL SPINE, LUMBAR SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Acupuncture two times a week for three weeks for the bilateral knees, cervical spine and lumbar spine is not medically necessary per the MTUS guidelines. The guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The documentation does not indicate that the patient has reduced or not tolerated pain medication or that surgery has occurred recently. It is also not clear whether the patient has had prior acupuncture as her injury occurred in 2010. There is no evidence that the patient is using this as an adjunct to physical rehabilitation. The request for acupuncture two times a week for three weeks is not medically necessary.

INTERNAL MEDICINE CONSULTATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna- Clinical Policy Bulletin: Weight Reduction Medications and Programs, Number: 0039

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92. Decision based on Non-MTUS Citation Aetna- Clinical Policy Bulletin: Weight Reduction Medications and Programs, Number: 0039

Decision rationale: Internal Medicine consultation is not medically necessary. The documentation indicates that an internal medicine consultation is requested for weight loss. The ACOEM guidelines state that a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement to a treatment plan. The documentation does not indicate a specific treatment plan for weight loss for this patient. The MTUS and ODG do not specifically address supervised weight loss program. Applicable guidelines were found in Aetna. Aetna considers medically necessary physician supervision of weight reduction programs (i.e., effective, appropriate, and essential diagnostic and therapeutic services) for a documented history of failure to maintain weight at 20 % or less above ideal or at or below a body mass index (BMI) of 27 when the following criteria are met: BMI is greater than or equal to 30 kg/m²; or a BMI greater than or equal to 27 and less than 30 kg/m² and one or more of the following comorbid conditions: coronary artery disease, diabetes mellitus type 2, hypertension (systolic blood pressure greater than or equal to 140 mm Hg or diastolic blood pressure greater than or equal to 90 mm Hg on more than one occasion), obesity, hypoventilation syndrome (Pickwickian syndrome), obstructive sleep apnea, or dyslipidemia (high-density lipoprotein (HDL) cholesterol less than 35 mg/dL ; or low-density lipoprotein (LDL) cholesterol greater than or equal to 160 mg/dL; or serum triglyceride levels greater than or equal to 400 mg/dL. Per Aetna, physician supervision of weight reduction programs is considered experimental and investigational when these criteria are not met. The documentation does not indicate that the patient has had a documented history of a failure to maintain weight at 20% or less above ideal or at a BMI of 27. The request for Internal Medicine consultation is not medically necessary.

NORCO: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: The prescription of Norco is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The patient has been on Norco without any indication that the pain has improved patient's pain or functioning to a significant degree. The MTUS guidelines state that opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. The guidelines state that opioids can be continued if the patient has returned to work and if the patient has improved functioning and pain. The documentation indicates that the patient is not improving in function or pain. The request for Norco does not indicate duration of use. The request for the prescription of Norco is not medically necessary.

CYCLO-KETO-LIDO: 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): 111-113.

Decision rationale: The prescription of Cyclo -Keto-Lido is not medically necessary per the MTUS guidelines. The request contains Ketoprofen 20%, Cyclobenzaprine 2%, and Lidocaine 5%. The MTUS does not recommend Lidocaine in a topical formulation such as a cream, lotion, or gel for neuropathic pain. The MTUS does not recommend topical Ketoprofen as it is not currently FDA approved for a topical application due to an extremely high incidence of photocontact dermatitis. The MTUS guidelines do not recommend topical cyclobenzaprine. The request also indicates no duration for this treatment. There is also no evidence of intolerance to oral medications. The request for the prescription of cyclo-keto-lido is not medically necessary.