

Case Number:	CM14-0113811		
Date Assigned:	08/01/2014	Date of Injury:	04/02/2004
Decision Date:	10/01/2014	UR Denial Date:	06/24/2014
Priority:	Standard	Application Received:	07/21/2014

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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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 52-year-old female who reported injury on 04/02/2012. The mechanism of injury was not submitted in the report. The injured worker has diagnosis of lateral epicondylitis; muscle calcification and ossification of the shoulder; osteoarthritis, nonspecific to the left leg; Chondromalacia of the right knee; neuritis/neuralgia of the lumbosacral spine, nonspecific, with spondylosis. Past medical treatment consists of physical therapy, the use of a home exercise program, the use of bracing, and medication therapy. Medications include Fexmid, Norco, fentanyl patches, over the counter NSAIDS, and antidepressants. The injured worker has also undergone knee injections and left knee total arthroplasty replacement. It was shown on the progress note dated 06/09/2014 that recent diagnostic studies were issued for the right knee, it was not indicated what was done. According to the same progress note, the injured worker had physical findings that included increased left knee pain with prolonged standing. It was noted in the report that the injured worker had a pain rate of 8/9 with medication and a severe 10/10 without. It was also noted that the injured worker had tenderness to palpation in the medial and lateral joints, parapatellar and right patellar tendon, positive patellofemoral crepitus, atrophy of the left quads, pain with McMurray's, right quad 5/5, left quad 4/5, and passive range of motion right and left flexion at 80 degrees, extension 0. The treatment plan is for the injured worker to continue the use of medications and have additional physical therapy for the knees bilaterally. The provider is also requesting that the injured worker have ultrasound treatment for the right knee. The rationale for Request for Authorization Form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Physical Therapy Visits for Bilateral Knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338, Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines: Physical Medicine Guidelines

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

Decision rationale: The request for physical therapy 8 sessions for the knees bilaterally is not medically necessary. The California MTUS Guidelines state that 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 alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and are expected to continue active therapies at home as an extension of the treatment process in order maintain improvement levels. There is a lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy of prior therapy. The guidelines recommend up to 10 visits of physical therapy; the amount of physical therapy visits that have already been completed on the injured worker's knees was unclear. Furthermore, there was no documentation submitted in the report showing that the injured worker was continuing with active therapies at home. Additionally, since it did not state in the submitted report how many physical therapy sessions the injured worker had already completed, with the request being for 8 additional physical therapy sessions, the injured worker is not within the MTUS Guidelines. As such, the request for physical therapy is not medically necessary.

1 Right Knee Diagnostic Ultrasound: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Therapeutic Ultrasound.

Decision rationale: The request for right knee ultrasound is not medically necessary. The Official Disability Guidelines do not recommended therapeutic ultrasound. Therapeutic ultrasound has been more effective than placebo in the treatment of plantar heel pain. There is little information available from trials to support the use of many physical medicine modalities for treating disorders of the ankle, foot and knee. Ultrasound, laser, short wave therapy, and electrotherapy have no added value in lateral ankle, knee, or foot injuries and are not recommended. Given the above, an ultrasound for the right knee is not recommended by the ODG. As such, the request for right knee ultrasound is not medically necessary.

Norco 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use Page(s): 78.

Decision rationale: The request for Norco 10/325 mg is not medically necessary. The California MTUS Guidelines recommend providing ongoing education on both the benefits and limitations of opiate treatment. The guidelines recommend the lowest possible dose should be prescribed to improve pain and function. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long the pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. Additionally, the submitted report did indicate that a urinalysis was done on 03/24/2014, showing that the injured worker was in compliance with her prescription medications. However, the documentation lacked any evidence of the injured worker having failed any non-opioid analgesics. Furthermore, the documentation also lacked evidence of the efficacy of the medication, a complete and accurate pain assessment. The request as submitted also lacked a frequency of the medication. As such, the request for Norco 10/325 mg is not medically necessary.

Fexmid 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Fexmid) Page(s): 41-42.

Decision rationale: The request for Fexmid 7.5 mg is not medically necessary. The MTUS Guidelines only recommend Fexmid as an option using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting the shortest course may be better. Treatment should be brief. The addition of Fexmid to other agents is not recommended. Fexmid is associated with treatment of 2 to 3 weeks for symptom improvement with lower back pain and is associated with drowsiness and dizziness. Additionally, the request as submitted is for Fexmid 7.5 mg with a quantity of 60, exceeding the recommended MTUS Guidelines for short term use. Efficacy of the medication was not provided, warranting the continuation of the medication. As such, the request for Fexmid is not medically necessary.