

Case Number:	CM14-0120230		
Date Assigned:	08/06/2014	Date of Injury:	12/27/2005
Decision Date:	10/02/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/29/2014

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 and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 65-year-old individual was reportedly injured on 12/27/2005. The mechanism of injury was not listed. The most recent progress note, dated 7/15/2014, indicated that there were ongoing complaints of bilateral knees pains and headaches. The physical examination demonstrated neurologically sensation was decreased over the lateral leg into the lateral foot, almost following the S1 dermatome pattern up to the knee bilaterally. An antalgic gait was due to left knee pain. Left knee examination was not performed due to recent surgery. Right knee range of motion was 0-120 with slight swelling. There was left hip positive tenderness to palpation over the anterolateral hip. Hip flexion and abduction were normal when compared to the contralateral side. Diagnostic imaging studies mentioned an MRI of the brain with date unknown, which was negative. Official radiological report was unavailable for review. Previous treatment included left total knee arthroplasty and right knee arthroscopy. A request had been made for Norco 10/325 mg, naproxen 550 mg, and massage therapy of the lumbar spine and was not certified in the pre-authorization process on 7/7/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg (one tablet 4-6 hours as needed for pain): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91 of 127.

Decision rationale: Norco (hydrocodone/acetaminophen) is a short acting opiate indicated for the management in controlling moderate to severe pain. This medication is often used for intermittent or breakthrough pain. The California MTUS guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in the pain or function with the current regimen. As such, this request for Norco is not medically necessary.

Naproxen 550mg (one tablet bid as needed for pain): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66 and 73 of 127..

Decision rationale: Antiinflammatories such as naproxen are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. According to the attached medical record, there is no reported decrease in pain and increased functional activity related directly to the use of this medication. Therefore, this request for naproxen is not medically necessary.

massage therapy -lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Page(s): 60 of 127..

Decision rationale: CA MTUS guidelines support the use of massage therapy as an adjunct to other treatments (i.e. physical therapy & exercise) and states it should be limited as to 4-6 visits in most cases. Given that the claimant has been through a course of massage therapy previously and the history of chronic knee and back pain is unchanged, the guidelines do not support the request. Therefore, massage therapy is not considered medically necessary. Also note, the treating physician did not address the number of sessions or frequency.