

Case Number:	CM14-0037323		
Date Assigned:	06/25/2014	Date of Injury:	06/17/2009
Decision Date:	07/23/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	03/27/2014

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 and 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:

This 63 year-old female Meat Clerk/Cook sustained an injury on 6/17/09 while employed by [REDACTED]. Request(s) under consideration include Prilosec 20mg, #60, Norco 10/325mg, #120, Physical therapy 3 times a week for 6 weeks, and Interferential Unit x1. The patient is s/p left total knee arthroplasty on 8/24/13. Report of 9/5/13 noted incision looked clear and was healing; range in left knee had flex/extension 70/5 degrees; tenderness to palpation over medial and lateral joint line. Treatment included suture removal. Report of 2/28/14 from the provider noted the patient with complaints of left knee pain, heart burn, abdominal pain, nausea. The patient has history of gallbladder surgery two years ago, right elbow surgery, one year ago, and left knee surgery less than one year ago. Exam showed healed surgical scar of left knee; no extremity edema, cyanosis or clubbing; sensory and motor exam intact with 5/5 muscle strength in all muscle groups; and DTR of 2+ bilaterally. Request(s) for Prilosec 20mg, #60, Norco 10/325mg, #120, Physical therapy 3 times a week for 6 weeks, and Interferential Unit x1 were non-certified on 3/13/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-regarding proton pump inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on NSAIDs, GI Symptoms and Cardiovascular risk Page(s): 68-69.

Decision rationale: Prilosec (Omeprazole) medication is for treatment of the problems associated with erosive esophagitis from GERD, or in patients with hypersecretion diseases. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Omeprazole (Prilosec). Submitted reports have not adequately described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any confirmed GI diagnosis to warrant this medication. The Prilosec 20mg, #60 is not medically necessary and appropriate.

Norco 10/325mg, #120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) page 74-96, On-Going Management Page(s): 74-96.

Decision rationale: Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in work status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain. The Norco 10/325mg, #120 is not medically necessary and appropriate.

Physical therapy 3 times a week for 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The Chronic Pain Guidelines, post-operative therapy allow for 24 visits over 10 weeks for arthroplasty over a postsurgical physical medicine treatment period of 4 months.

Submitted reports have not adequately demonstrated the indication to support for a total of additional 18 physical therapy visits without documented functional improvement from previous therapy rendered. The patient's TKA is now almost 11 months without specific documented functional limitations or complications. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy 3 times a week for 6 weeks is not medically necessary and appropriate.

Interferential Unit x1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-118.

Decision rationale: The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased activities of daily living (ADLs), decreased medication dosage, increased pain relief or improved work status derived from any transcutaneous electrotherapy to support for interferential unit for this chronic 2009 injury. The Interferential Unit x1 is not medically necessary and appropriate.