

Case Number:	CM14-0067581		
Date Assigned:	08/08/2014	Date of Injury:	05/31/2013
Decision Date:	10/02/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/12/2014

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 Occupational Medicine 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 is a 62-year-old female who has reported low back, neck, knee, and ankle pain after an injury on May 31, 2013. Diagnoses have included degenerative joint disease, ankle sprain, sciatica, and spine strain/sprain. Treatment has included Supartz and steroid injections for the knees, medications, prolonged total disability status prescribed by the treating physicians, arthroscopic knee surgery prior to this injury, physical therapy, acupuncture, and chiropractic. The Request for Authorization of April 15, 2014 was for the items now under Independent Medical Review. The treating physician listed on this Request for Authorization evaluated the injured worker on January 8, 2014. The symptoms were pain in the lower extremities, feet, and chest. No current medications were listed. No evidence was presented for a specific gait disturbance. The left knee and left ankle were tender with swelling. The ankle had an unspecified limited range of motion. The diagnoses were knee pain, degenerative joint disease, ankle pain, and gait instability. The treatment plan included the items now under Independent Medical Review. The urine drug screen was stated to be for medication management and compliance. No indications or definition were given for the genetics test. The kind of knee brace was not defined or discussed. The specific indications for any of the medications for this injured worker were not discussed; each of the medications was described generically. There was no discussion of any prior physical therapy or acupuncture. The home safety kit was not defined. Cartivisc and Napro cream were not defined. The agreed medical evaluation (AME) on February 17, 2014 noted that prior physical therapy did not help, and that the physical therapy modalities given by the chiropractor give temporary relief. Pain was present with weight bearing activities and there were problems sleeping due to "symptoms". The record review included the chiropractor reports during 2013, during which time chiropractic, physical therapy, and acupuncture were given. Work status "temporarily totally disabled". The AME on

April 28, 2014 discussed knee MRIs that showed degenerative joint disease. Work restrictions included preclusions against prolonged and repetitive weight bearing activities. There was no recommendation for any assistive devices. An orthopedic evaluation dated March 11, 2014 listed neck, chest, low back, knee, and ankle pain after a chest contusion at work. Note was made of prior treatment with NSAIDs, Zofran, physical therapy, opioids, chiropractic, and acupuncture. Per the treating chiropractor records, acupuncture, physical therapy, and chiropractic were given from October 2013 to January 2014. The gait was described as normal. The treatment plan included a knee steroid injection, ibuprofen, Flexeril, lumbar MRI, knee MRIs, and referral for chest pain evaluation. The primary treating physician's progress reports (PR-2) dated March 25, 2014 to July 10, 2014 refer to knee and low back pain. None of the reports address the items now under Independent Medical Review. On April 22, 2014, Utilization Review non-certified the items now under Independent Medical Review, noting a request of April 15, 2014. In general, the non-certifications were based on lack of sufficient clinical evaluation, lack of sufficient indications, and the cited guidelines (MTUS and the Official Disability Guidelines).

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy (12 sessions, 2-times per week for 6-weeks): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOME Practice Guidelines, Chapter 6: Pain, Suffering and the Restoration of Function, page(s) 114

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, functional improvement, Physical Medicine Page(s): 9, 98-99.

Decision rationale: The treating physician has not provided an adequate prescription, which must contain diagnosis, duration, frequency, and treatment modalities, at minimum. Per the California MTUS Guidelines, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. The treating physician has not stated a purpose for the current physical therapy prescription. It is not clear what is intended to be accomplished with this physical therapy, given that it will not cure the pain and there are no other goals of therapy. The current physical therapy prescription exceeds the quantity recommended in the California MTUS Guidelines. This patient has already completed courses of Physical Medicine, which exceed the quantity of visits recommended. The chiropractor provided physical therapy over the course of months. No medical reports identify specific functional deficits, or functional expectations for further Physical Medicine. The Physical Medicine prescription is not sufficiently specific, and does not adequately focus on functional improvement. There is no evidence of functional improvement from the physical therapy already completed. Work status was "temporarily totally disabled" while physical therapy was in progress, indicating a complete lack of functional improvement. Additional Physical Medicine is not medically necessary based on the California MTUS Guidelines, lack of sufficient emphasis on functional improvement, lack of a complete prescription, an excessive quantity of prescribed visits, and the failure of Physical Medicine to

date to result in functional improvement as defined in the California MTUS Guidelines. Therefore, the request is not medically necessary.

Acupuncture (12 sessions, 2-times per week for 6-weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The prescription for additional acupuncture is evaluated in light of the California MTUS Guidelines recommendations for acupuncture, including the definition of "functional improvement". Per the California MTUS Guidelines, 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 treating physician has not provided the specific indications for acupuncture as listed in the guidelines. There is no discussion of issues with pain medications, or functional recovery in conjunction with surgery and physical rehabilitation. The treating physician did not discuss the prior courses of acupuncture. An initial course of acupuncture is 3-6 visits per the California MTUS Guidelines. The prescription is for 12 visits, which exceeds the quantity recommended. Since the completion of the previous acupuncture visits, the treating physician or chiropractor have not provided evidence of clinically significant improvement in activities of daily living or a reduction in work restrictions. Given that the focus of acupuncture is functional improvement, function (including work status or equivalent) must be addressed as a starting point for therapy and as a measure of progress. As discussed in the California MTUS Guidelines, chronic pain section, the goal of all treatment for chronic pain is functional improvement, in part because chronic pain cannot be cured. The injured worker remains on "temporarily totally disabled" status, which is such a profound degree of disability that the injured worker is largely bedbound and unable to perform basic activities of daily living. This implies a failure of all treatment, including acupuncture. There is no evidence of a reduction in the dependency on continued medical treatment. No additional acupuncture is medically necessary based on lack of functional improvement as defined in the California MTUS Guidelines. Therefore, the request is not medically necessary.

Four-Pronged Cane for Stability: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Walking Aids

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter, Walking aids (canes, crutches, braces, orthoses, & walkers)

Decision rationale: The treating physician did not provide an adequate clinical evaluation which adequately addressed ongoing functional deficits, prior treatment, and specific indications for the cane. The AME did not recommend a cane or mobility device. The orthopedic evaluation in

March 2014 noted a normal gait. Canes are not addressed in the California MTUS Guidelines. The cited Official Disability Guidelines discuss some of the benefits and and indications for various walking aids. The treating physician did not provide sufficient information in his evaluation to demonstrate medical necessity for a walking aid. Therefore, the request is not medically necessary.

Left Knee Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Walking Aids

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340, 346.

Decision rationale: The ACOEM Practice Guidelines state that a knee brace can be used for patellar instability, ACL tear, or MCL instability, although its benefits may be more related to increasing the patient's confidence than strictly medical. A brace would usually be needed if the patient will be stressing the knee under load, such as climbing or carrying. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program. Guidelines also state that braces may be used for acute injury and functional bracing may be used as part of a rehab program. Prophylactic bracing or prolonged bracing for anterior cruciate ligament deficiency is not recommended. In this case, the treating physician did not discuss the kind of brace prescribed or the specific indications. None of the indications in the California MTUS Guidelines were listed. The brace is therefore not medically necessary.

Home Safety Kit (IW Currently Fall Risk): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

Decision rationale: The treating physician did not define a "home safety kit". There is no conventional medical treatment or equipment with this name. It is therefore not possible to further address medical necessity for an unspecified item like this. The California MTUS Guidelines, in the chapters most likely to address care for the lower extremity (listed above), does not mention this "kit". The Official Disability Guidelines do not mention this "kit" in any portion of the guidelines. Medical necessity has not been established by the treating physician, and due to the ambiguous nature of the request, specific medical evidence is not available to address medical necessity further.

Predisposition Genetics Drug Test: Upheld

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

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 Genetic testing for potential opioid abuse

Decision rationale: The California MTUS Guidelines are silent on this topic. The Official Disability Guidelines recommends against genetic testing for opioid abuse, which is the presumed nature of this test. The treating physician did not define this test and provided no specific indications. The test is therefore not medically necessary.

Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Criteria for use, Misuse/Addiction Page(s): 78, 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, drug screens, steps to avoid misuse/addiction Page(s): 77-80, 94, 43, 77, 78, 89, 94. Decision based on Non-MTUS Citation Updated ACOEM Practice Guidelines, 8/14/08, Chronic Pain, page(s) 138, urine drug screens.

Decision rationale: While recommended as an option, there needs to be present of those clinical signs that warrant appropriate drug testing. The progress note presented is completely illegible and does not establish that there is any abuse, abuse potential, intoxication, drug diversions or other drug seeking behaviors. As such the medical necessity for this intervention is not been established.

Napro Cream (15%, 240-grams): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Applications Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Topical Medications Page(s): 60, 111-113.

Decision rationale: The treating physician did not define the ingredients of Napro cream. Given that many possible ingredients may be used in topical compounds, and that many are not indicated per the California MTUS Guidelines, Napro cream is not presumed to be medically necessary. Per the California MTUS Guidelines, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical necessity for these topical agents, they are not medically necessary on this basis at minimum. The California MTUS Guidelines states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The topical agents prescribed are not medically necessary based on the California MTUS Guidelines, lack of medical evidence, and lack of a clear ingredient list.

Trazadone (100mg, #30): Upheld

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

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, insomnia

Decision rationale: The treating physician did not discuss the indications for trazodone in this case. Trazodone may be indicated for depression as well as short term treatment of insomnia. Given the lack of any clear indications described by the treating physician, the trazodone is not medically necessary. The California MTUS Guidelines does not address trazodone. The Official Disability Guidelines discusses trazodone as an antidepressant as well as a hypnotic. No physician reports describe the specific criteria for a sleep disorder or depression. Treatment of depression or a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. Trazodone is therefore not medically necessary.

Ondansetron ODT (8mg, #10): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Opioids for Nausea Pain Chapter

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, antiemetics

Decision rationale: The California MTUS Guidelines does not address antiemetics. The Official Disability Guidelines, in the citation above, recommend ondansetron for vomiting secondary to chemotherapy, radiation therapy, gastroenteritis, or postoperatively. None of these indications were discussed or evident. Ondansetron is therefore not medically necessary.

Cyclobenzaprine (10mg, #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 Muscle relaxants Page(s): 41, 63.

Decision rationale: The California MTUS Guidelines for Chronic Pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The treating physician did not give the specific indications in this case, and his evaluation did not

provide any diagnosis of back pain. The quantity prescribed implies long term use, not a short period of use for acute pain. Cyclobenzaprine, per the California MTUS Guidelines, is indicated for short-term use only and is not recommended in combination with other agents. This injured worker has been prescribed multiple medications along with cyclobenzaprine. Per the MTUS, cyclobenzaprine is not indicated and is not medically necessary.

Cartivisc (500/200/150mg, #90): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Medical Foods

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: Cartivisc is apparently glucosamine, chondroitin, and methylsulfonylmethane, although the treating physician did not define the ingredients or provide the specific indications for the ingredients. The California MTUS Guidelines recommends glucosamine for arthritis (primarily of the knee), and the glucosamine should be of a specific type defined in the California MTUS Guidelines. The form of glucosamine used in this case may not be the proper form recommended in the California MTUS Guidelines, as the California MTUS Guidelines describes a specific chemical form on which medical evidence is based and the treating physician has not discussed the nature of the ingredients. Other forms lack scientific credibility. Chondroitin is not indicated per the California MTUS Guidelines. Methylsulfonylmethane (MSM) has no evidence-based indications. Cartivisc is not medically necessary based on the California MTUS Guidelines.

Ketoprofen (20%) Transdermal 240-grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Applications Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Topical Medications Page(s): 60, 111-113.

Decision rationale: Per the California MTUS Guidelines, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. The California MTUS Guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical ketoprofen is not FDA approved, and is not recommended per the California MTUS Guidelines. The topical agents prescribed are not medically necessary based on the California MTUS Guidelines, lack of medical evidence, and FDA directives.