

Case Number:	CM14-0190438		
Date Assigned:	11/21/2014	Date of Injury:	12/21/2007
Decision Date:	01/09/2015	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	11/14/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 64-year-old male with a 12/21/07 date of injury, and status post right total hip arthroplasty 11/14/02. At the time (10/24/14) of request for authorization for physical therapy for the cervical, thoracic, lumbar and left knee, twice weekly for six weeks, Fluriflex 180 grams & TGHOT 180 grams, and Lumbosacral orthosis, flexible, there is documentation of subjective (neck pain that radiates in the C7 dermatomes; low back pain that radiates in the bilateral L4 and L5 dermatomes; 5/10 pain in the bilateral knees) and objective (cervical, thoracic, and lumbar paraspinous tenderness and spasms; cervical and lumbar restricted range of motion; bilateral knee grade 2 tenderness to palpation and positive McMurray bilaterally) findings, current diagnoses (cervical spine strain/sprain exacerbation, cervical spine disc protrusion, thoracic spine strain/sprain, lumbar spine strain/sprain, bilateral knee strain/sprain, bilateral knee meniscal tear, right knee synovitis and chondromalacia, and left foot plantar fasciitis), and treatment to date (medications and physical therapy). The number of physical therapy visits completed to date cannot be determined. Regarding the requested physical therapy for the cervical, thoracic, lumbar and left knee, twice weekly for six weeks, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy completed to date. Regarding the requested lumbosacral orthosis, flexible, there is no documentation of compression fractures, spondylolisthesis, or documented instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the cervical, thoracic, lumbar and left knee, twice weekly for six 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 Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck and Upper Back, Low Back, Knee; Physical Therapy, and on Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of sprains and strains of back not to exceed 10 visits over 8 weeks. In addition, ODG recommends a limited course of physical therapy for patients with a diagnosis of sprains and strains of knee not to exceed 12 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of cervical spine strain/sprain exacerbation, cervical spine disc protrusion, thoracic spine strain/sprain, lumbar spine strain/sprain, bilateral knee strain/sprain, bilateral knee meniscal tear, right knee synovitis and chondromalacia, and left foot plantar fasciitis. In addition, there is documentation of previous physical therapy. However, there is no documentation of the number of previous physical therapy sessions and, if the number of treatments have exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy completed to date. Therefore, based on guidelines and a review of the evidence, the request for physical therapy for the cervical, thoracic, lumbar and left knee, twice weekly for six weeks is not medically necessary.

Fluriflex 180 grams & TGHOT 180 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in a 0.0375% formulation, Baclofen and other muscle relaxants, and Gabapentin and other anti-epilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of cervical spine strain/sprain exacerbation, cervical spine disc protrusion, thoracic spine strain/sprain, lumbar spine strain/sprain, bilateral knee strain/sprain, bilateral knee meniscal tear, right knee synovitis and chondromalacia, and left foot plantar fasciitis. However, Fluriflex 180 grams contain at least one drug class (muscle relaxants (Cyclobenzaprine)) that is not recommended. In addition, TGHOT contains at least one drug (Gabapentin) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Fluriflex 180 grams & TGHOT 180 grams is not medically necessary.

Lumbosacral orthosis, flexible: 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) Low Back, Lumbar Supports

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar Supports

Decision rationale: MTUS reference to ACOEM identifies that lumbar support have not been shown to have any lasting benefit beyond acute phase of symptom relief. ODG identifies documentation of compression fractures, spondylolisthesis, or documented instability, as criteria necessary to support the medical necessity of lumbar support. Within the medical information available for review, there is documentation of diagnoses of cervical spine strain/sprain exacerbation, cervical spine disc protrusion, thoracic spine strain/sprain, lumbar spine strain/sprain, bilateral knee strain/sprain, bilateral knee meniscal tear, right knee synovitis and chondromalacia, and left foot plantar fasciitis. However, there is no documentation of compression fractures, spondylolisthesis, or documented instability. Therefore, based on guidelines and a review of the evidence, the request for lumbosacral orthosis, flexible is not medically necessary.