

<b>Case Number:</b>	CM15-0008505		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	06/16/2011
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	12/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 was a 70-year-old male, who sustained an industrial injury, June 6, 2011. According to progress note of November 4, 2014, the injured workers chief complaint was left knee pain. The visit was a consultation for left knee replacement surgery. The injured worker failed conservative treatment of pain medication, physical therapy and home exercise program. The injured worker was diagnosed with bilateral knee osteoarthritis, right knee replacement, left knee dysfunction, failure of exercise program, and chronic pain. The injured worker previously received the following treatments laboratory studies, Tramadol, Relafen, Pain consultant, right knee arthroplasty, physical therapy, massage, home exercise program. November 4, 2014, the primary treating physician requested authorization for Duracef 500mg #7, Norco 10/325mg #180, 8 postoperative physical therapy visits for the left knee, 1 re-evaluation visit in 6 weeks for postoperative services for left knee arthroplasty surgery. On December 29, 2014, the Utilization Review denied authorization for Duracef 500mg #7, Norco 10/325mg #180, 8 postoperative physical therapy visits for the left knee, 1 re-evaluation visit in 6 weeks. The denial was based on the MTUS/ACOEM and ODG guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Duracef 500mg #7:** 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cefadroxil (Duricef) <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, Cefadroxil "Recommended as first-line treatment for skin & soft tissue infections. See Skin & soft tissue infections (SSTI)." There is no documentation that the patient developed soft tissue infection sensitive to Duracef 500mg #7. Therefore, the request is not medically necessary.

**Norco 10/325 mg #180:** 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 Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: "(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework." According to the patient file, he underwent a right knee total arthroplasty in July 2014. In the case of post-operative pain, the use of opioid medication is recommended for a maximum of 2 weeks. The patient has been using Norco, since his surgery, without objective documentation of pain and functional improvement. Therefore, the prescription of Norco 10/325mg #180 is not medically necessary.

**8 post operative physical therapy visits for the left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

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

**Decision rationale:** According to MTUS guidelines, Physical Medicine is "Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)." There is no documentation of the efficacy and outcome of previous physical therapy sessions. There is no documentation that the patient cannot perform home exercise. Therefore, the request for 8 post operative physical therapy visits for the left knee is not medically necessary.

**1 re-evaluation in 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 Chronic pain programs, early intervention Page(s): 32-33.

**Decision rationale:** According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a surgery evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated: "Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach: (a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. (f) Loss of employment for greater than 4 weeks. The most discernible indication of at risk status is lost time from work of 4 to 6 weeks. (Mayer 2003)." The provider did not document lack of pain and functional improvement that require a re-evaluation.

The requesting physician did not provide a documentation supporting the medical necessity for the re-evaluation. The documentation did not include the reasons, the specific goals and end point for the visit. Therefore, the request for 1 re-evaluation in 6 weeks is not medically necessary.

