

Case Number:	CM15-0008693		
Date Assigned:	01/26/2015	Date of Injury:	04/16/2014
Decision Date:	03/26/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/15/2015

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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 is a 40-year-old male who reported an injury on 04/16/2014. The mechanism of injury was not stated. The current diagnoses include left knee strain, left knee contusion, and left knee meniscal tear. The injured worker presented on 11/06/2014 with complaints of persistent pain in the left knee rated 8/10. Upon examination, there was 2 to 3+ tenderness to palpation, positive McMurray's sign, and intact sensation. The injured worker reported an improvement in symptoms with physical therapy. Recommendations included continuation of the current medication regimen of tramadol 50 mg, Ambien 150 mg, and TG Hot cream. The injured worker was instructed to continue physical therapy once per week for 6 weeks. There was no Request for Authorization Form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 SESSIONS OF PHYSICAL THERAPY TO INCLUDE: ([REDACTED]): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: The California MTUS Guidelines state 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. There was no documentation of the previous course of physical therapy with evidence of objective functional improvement. Additional treatment would not be supported. Furthermore, the current request includes CPT codes for diathermy and ultrasound therapy, which are not recommended by the California MTUS Guidelines. Given the above, the request is not medically appropriate.

1 PRESCRIPTION FOR TRAMADOL 50 MG, #60 (THROUGH [REDACTED]): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82..

Decision rationale: The California MTUS Guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized tramadol 50 mg for an unknown duration. There is no documentation of objective functional improvement. The injured worker continues to report high levels of pain. There was no frequency listed in the current request. As such, the request is not medically appropriate.

1 PRESCRIPTION FOR AMBIEN 10 MG, #30 (THROUGH [REDACTED]): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain: Insomnia Treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis of insomnia. Additionally, there was no documentation of a failure to respond to nonpharmacologic treatment for insomnia prior to the initiation of a prescription product. There was also no frequency listed in the request. Given the above, the request is not medically appropriate.