

Case Number:	CM15-0201121		
Date Assigned:	10/16/2015	Date of Injury:	05/30/2014
Decision Date:	12/21/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	10/13/2015

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 York

Certification(s)/Specialty: Pediatrics, Internal 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 is a 53 year old male, who sustained an industrial injury on 5-30-2014. The injured worker was being treated for neck pain, left shoulder pain, left hip pain, and left knee pain. Treatment to date has included left knee arthroscopic surgery 11-2014 with at least 4 sessions of post-operative physical therapy (stopped due to pain), left shoulder surgery 2-25-2015 with no reported physical therapy, aqua therapy for the neck and back, and medications. Currently (9-01-2015), the injured worker complains of persistent pain in his left shoulder and left knee, not rated. Current medication regimen was not noted. His work status was total temporary disability. Function with activities of daily living was not noted. An examination of the left knee and left shoulder was not documented on 9-01-2015 or 8-04-2015 and the physical examination dated 7-21-2015 noted only the injured worker's height and weight. Urine toxicology (7-07-2015) was positive for Tramadol and Hydrocodone. A previous progress report (4-22-2015) noted that he reported authorization for physical therapy to resume for both his knee and shoulder. The number of sessions completed to date was unclear. The treatment plan included physical therapy for the left shoulder and left knee (2x4), Tramadol HCL 50mg #90, Diclofenac Sodium 100mg #60, Pantoprazole Sodium 20mg #60, CL 150g (Cyclobenzaprine 10%, Lidocaine 2%), FL 150g (Flurbiprofen 20%, Lidocaine 5%), and GAC 150g (Gabapentin 10%, Amitriptyline 5%, Capsaicin 0.025%).

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 4 weeks for the left shoulder and left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Shoulder Chapters - Physical therapy.

Decision rationale: Physical therapy is recommended by MTUS for chronic pain if caused by musculoskeletal conditions. With regards to the shoulder and leg it is recommended as an option. There are specific guidelines depending on where in the natural course of the illness the IW may be at the time of referral. For sprained shoulder the recommendation is 10 visits over 8 weeks and for sprain of the leg the recommendation is 12 visits over 8 weeks. There is little information regarding number of prior physical therapy visits. The request is not medically necessary or unable to be affirmed.

Tramadol HCL 50mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The IW is documented to be on an opioid for pain relief. Documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary or reasonable.

Diclofenac Sodium 100mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: According to the MTUS and ODG guidelines NSAID's are recommended for osteoarthritis, chronic back pain and acute exacerbations of back pain. According to the progress notes provided the IW was on Voltaren 100 mg daily for shoulder and leg pain.

Additionally, the ODG formulary states that Voltaren is a second line agent and there are no records of a trial of a first line agent. This request is not medically necessary or appropriate.

Pantoprazole Sodium 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to MTUS guidelines it is necessary to determine if the patient is at risk for gastrointestinal events. Risk factors are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. Progress notes do not note any symptoms or risk factors. Pantoprazole is FDA approved for treatment of erosive esophagitis and hyper secretory conditions neither of which is present in the IW. This request is not medically necessary or appropriate.

CL 150g (Cyclobenzaprine 10%, Lidocaine 2%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: With regards to the Cyclobenzaprine/Lidocaine compound, Cyclobenzaprine is not FDA approved for topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Even though lidocaine is approved for topical use this cannot be approved due to other components in the compound. This request is not medically appropriate or reasonable.

FL 150g (Flurbiprofen 20%, Lidocaine 5%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Topical NSAID's are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen is not FDA

approved for topical use. Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. However, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This request is not medically necessary or appropriate.

GAC 150g (Gabapentin 10%, Amitriptyline 5%, Capsaicin 0.025%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Topical analgesics are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Capsaicin is approved for topical use in patients who are intolerant to other treatments. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Amitriptyline and gabapentin are not FDA approved for topical use. This request is not medically necessary or appropriate.