

Case Number:	CM15-0204348		
Date Assigned:	10/21/2015	Date of Injury:	10/05/2000
Decision Date:	12/03/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/19/2015

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

Certification(s)/Specialty: Preventive Medicine, Occupational 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 66-year-old female who sustained an industrial injury on 10-5-2000 and has been treated for traumatic arthritis of the hip, failed total hip arthroplasty, lumbar radiculopathy, osteoarthritis of the right knee, degenerative disc disease, and status post lumbar fusion. On 9-17-2015 the injured worker reported mild pain, and difficulty putting on shoes and socks, walking outside or using stairs, and she was using a power scooter for "support." She had reported that her pain was now over her right knee. Objective evaluation noted right hip flexion 90 degrees and 20 degrees of external rotation in flexion, right knee 90 degrees of flexion and 0 degrees of extension. Documented treatment includes total right hip arthroplasty with complex revision on 5-18-2015 and 6-9-2015, and inpatient daily physical and occupational therapy. The injured worker was supposed to receive in-home physical therapy post-surgery but this was cancelled. Medications include Oxycodone, Norco, Voltaren Gel, and Celebrex and she has been taking these since at least 5-2015. Documentation is not provided relating to pain rating or the response to medication treatment. The treating physician's plan of care includes a request for authorization submitted 9-21-2015 for post-surgical outpatient physical therapy 1-2 times per week for 4-6 weeks "to improve range of motion to include severe right knee osteoarthritis," but these were denied on 9-25-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 1 to 2 times per week for 4 to 6 weeks (1-2 x 4-6): Upheld

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

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

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified, receive 9-10 visits over 8 weeks. In this case, the injured worker has completed at least 24 physical therapy sessions since (May-2015). She then continued with home-based physical therapy that was cancelled for unknown reasons. The injured worker should be able to continue with a self-paced, home-based exercise program at this point. The request for physical therapy 1 to 2 times per week for 4 to 6 weeks (1-2 x 4-6) is determined to not be medically necessary.

Voltaren gel 1% with 1 refill: 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, NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Voltaren Gel 1% is FDA approved and indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). In this case, there is no rationale for prescribing a topical NSAID as well as an oral NSAID. Additionally, there is a lack of objected evidence of pain relief or functional improvement with the prior use of this medication. The request for Voltaren gel 1% with 1 refill is determined to not be medically necessary.

Oxycodone 10 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Weaning of Medications.

Decision rationale: The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. In this case, the injured worker is being prescribed two short-acting opioids without documented rationale. Additionally, there is a lack of objective documentation of pain relief and functional improvement with the prior use of this medication. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Oxycodone 10 mg #60 is determined to not be medically necessary.