

Case Number:	CM15-0028374		
Date Assigned:	02/20/2015	Date of Injury:	09/09/1970
Decision Date:	05/01/2015	UR Denial Date:	01/25/2015
Priority:	Standard	Application Received:	02/15/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 44 year old female, who sustained an industrial injury on 3/12/13. She has reported right and low back injury. The diagnoses have included right shoulder arthroscopic surgery, right upper extremity radiculopathy, right medial epicondylitis bilateral lower extremity radiculopathy and right knee instability. Treatment to date has included physical therapy, acupuncture, oral medications, topical medications and right knee surgery. Currently, the injured worker complains of intermittent right knee pain with improvement with physical therapy and low back pain, worsened with physical therapy, shoulder pain and elbow pain. Progress note dated 1/9/15 revealed decreased pain intensity and frequency and improved activities of daily living. On 1/25/15 Utilization Review non-certified physical therapy 2 times a week for 6 weeks, noting the lack of documentation regarding prior physical therapy to substantiate the need for additional therapy; transport to and from medical appointments, noting there is no evidence the injured worker is homebound; acupuncture 3 times week for 2 weeks, noting the lack of objective outcome of prior acupuncture to substantiate further treatment; Cyclo 2% cream 2 times day 60gm with 1 refill, noting it is not recommended as being ineffective treatment approach; and Tramadol cream 2 times a day 240mg with 1 refill, noting the lack of documentation of oral intolerance. The MTUS, ACOEM Guidelines, and ODG were cited. On 2/15/15, the injured worker submitted an application for IMR for review of physical therapy 2 times a week for 6 weeks, transport to and from medical appointments, acupuncture 3 times week for 2 weeks, Cyclo 2% cream 2 times day 60gm with 1 refill and Tramadol cream 2 times a day 240mg with 1 refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 x week for 6 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: This patient had an industrial injury on 3/12/2013, with complaints of right knee pain, s/p physical therapy (2013), and s/p right knee arthroscopy with chondroplasty (partial meniscectomy) on 11/18/2014. Physical therapy (PT) sessions are recommended after orthopedic procedures. PT recommendations for post-surgical arthroscopy/chondroplasty are 12 visits over 12 weeks. This patient was seen in follow-up on 1/9/15 and PT was recommended at that time. Although this patient received PT prior to the surgical procedure in 2013, there was no PT after surgery. Medical necessity of the requested 12 physical therapy sessions (2x6) has been established for this patient s/p right knee arthroscopy/ chondroplasty. The requested PT sessions are medically necessary.

Transport to and from medical appointments: 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), Knee & Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Transportation (to and from appointments).

Decision rationale: According to the ODG, transportation to and from medical appointments in the same community is for patients with disabilities, preventing them from self-transport. This applies to patients with disabilities preventing them from self-transport who are age 55 or older and need a nursing home level of care. In this case, there is no evidence that the patient is home-bound, to substantiate the need for transportation. Medical necessity of the requested service has not been established. The requested transportation to-and-from medical appointments is not medically necessary.

Acupuncture 3 x week for 2 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented, as defined by the guidelines further treatment will be considered. In this case, there is documentation of previous acupuncture visits; however, there is no documentation of the previous number of acupuncture treatments completed or documentation of objective improvement with previous treatments. In addition, given the associated request for physical therapy, there is no documentation of a rationale for providing concurrent physical modalities. Medical necessity for acupuncture (3x6) has not been established. The requested services are not medically necessary.

Cyclo 2% cream bid 60 gm with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111 and 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Topical analgesics.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic is Cyclobenzaprine 2% cream. In this case, the requested topical agent is a muscle relaxant, Cyclobenzaprine 2% Cream. Cyclobenzaprine is not recommended as a topical agent, per CA MTUS guidelines. In addition, there is no documentation of intolerance to other previous oral medications. Medical necessity for the requested topical cream is not established. The requested topical cream is not medically necessary.

Tramadol cream bid 240 gm with 1 refill: 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 Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Topical Analgesics.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic is Cyclobenzaprine 2% cream. In this case, the requested topical agent is Tramadol cream. Tramadol is not FDA approved for a topical application. It is evident from the records that the patient is able to use oral medications and there is no rationale provided for the use of this topical cream. Medical necessity for the requested topical analgesic has not been established.