

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0037828 | | |
| Date Assigned: | 03/06/2015 | Date of Injury: | 08/20/2013 |
| Decision Date: | 05/01/2015 | UR Denial Date: | 01/30/2015 |
| Priority: | Standard | Application Received: | 02/27/2015 |

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 55-year-old male who sustained an industrial injury on 8/20/13. Injury occurred when there was an explosion and he jumped out an attic access door and landed on the hard surface below, injury his left knee and hip. The 12/17/14 treating physician report cited complaints of low back pain with numbness in both legs, and left hip pain. He was using Tramadol 1 table twice a day and Tylenol #3 once a day for pain, but it didn't work as well as Norco. He noted functional improvement and pain reduction with current medications. Physical exam documented moderate loss of lumbar range of motion, positive bilateral straight leg raise, and decreased S1 sensation bilaterally. The diagnosis was lumbar herniated nucleus pulposus with radiculopathy, severe left hip degenerative joint disease, mild right knee internal derangement, and left knee internal derangement. The patient was to proceed with orthopedic evaluation for left hip pain. Norco was prescribed. The 1/15/15 orthopedic report cited constant severe left hip pain, increased with sitting, standing, and rising from a chair or the car. Left hip exam documented very painful and limited motion with no clicking, popping or catching. There was 4/5 abductor strength. There was severe groin pain in flexion, adduction, internal and external rotation. Trendelenburg was positive. The treatment plan recommended left total hip arthroplasty. The 1/15/15 left hip x-rays documented severe narrowing of the joint space with complete bone-on-bone contact. There was severe osteophyte formation and significant acetabulum and femoral head cyst formation. The femoral head appeared flattened and egg shaped. The 1/30/15 utilization review certified requests for left total hip arthroplasty, pre-operative testing, 6 visits of initial post-operative physical therapy, walker, bedside commode,

Robaxin 750 mg #60, Xeralto 10 mg #21, Cipro 500 mg #10, and hip x-rays. The request for a cold therapy unit was modified to a 7-day rental. A non-specific request for Percocet (no dosage or quantity) was modified to Percocet 5/325 mg #60. The requests for additional post-operative physical therapy 3 times weekly were denied pending completion of the initial course of post-op therapy and documentation of functional benefit. The request for Oxycontin was non-certified as there was no documentation why the injured worker would need a long-acting narcotic agent. The request for Neurontin was non-certified as there was no documentation of neuropathic pain. On 2/27/15, the injured worker submitted an application for IMR for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit for the left hip: 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 Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis: Cryotherapy.

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines indicate that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following lower extremity surgery. The 1/30/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.

Additional post-operative physical therapy, three times weekly, for the left hip: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The California Post-Surgical Treatment Guidelines for surgical treatment of hip arthroplasty suggest a general course of 24 post-operative visits over 10 weeks during the 4-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 1/30/15 utilization review recommended certification of 6 initial post-op physical therapy visits. There is no compelling reason submitted to support the medical necessity of 12 additional physical therapy visits at this time, pending completion of initial care. Therefore, this request is not medically necessary.

Percocet, strength and quantity unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Percocet Page(s): 76-80, 92, 97.

Decision rationale: The California MTUS guidelines recommend Percocet for moderate to severe pain on an as needed basis for pain. Short-acting opioids, also known as "normal-release" or "immediate-release" opioids, are seen as an effective method in controlling both acute and chronic pain, and would be reasonable for post-op pain management. However, the 1/30/15 utilization review recommended certified of Percocet 5/325 mg #60. There is no compelling reason to support the medical necessity of additional opioid medication at this time. Therefore, this request is not medically necessary.

Oxycontin, strength unspecified, forty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Oxycodone Page(s): 76-80, 97.

Decision rationale: The California MTUS guidelines indicate that Oxycontin was a controlled release formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Oxycontin is not indicated for use as an as needed analgesic. Guideline criteria have not been met. There is no indication that this patient would require around-the-clock analgesia for an extended period of time. A request for an as needed opioid medication has been found to be medically necessary. There is no compelling reason to support the medical necessity of an additional opioid for pain management. Therefore, this request is not medically necessary.

Neurontin 300 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-22.

Decision rationale: The California MTUS guidelines indicate anti-epilepsy drugs (AEDs) such as Neurontin may be used in the treatment of neuropathic pain, although most randomized controlled trials have been directed at postherpetic neuralgia and diabetic neuropathy. Neurontin is reported as a first line treatment for neuropathic pain, but is not recommended for post-

operative pain. Guideline criteria have not been met. Records indicate that this patient has a lumbar herniated nucleus pulposus and is being managed by another physician for his neuropathic pain complaints. Given the absence of support for post-operative pain management, this request is not medically necessary.