

Case Number:	CM15-0042873		
Date Assigned:	03/10/2015	Date of Injury:	05/13/2003
Decision Date:	04/17/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/22/2015

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: Utah, Arkansas
 Certification(s)/Specialty: Family Practice

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 63 year old male, who sustained an industrial injury on 05/13/2003. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having localized primary osteoarthritis of the lower leg and derangement of the medial meniscus not elsewhere classified and not otherwise specified. Treatment to date has included medication regimen, use of a single point cane, use of ice, and home exercise program. In a progress note dated 10/21/2014 the treating provider reports complaints of the right knee locking and pain to the left knee. The pain is described as sharp, shooting, and aching pain and is rated a six on a scale of zero to ten at its worst and a four out of ten at its best. The injured worker also has associated symptoms of numbness, tingling, swelling, locking, and weakness. The treating physician requested a physical therapy evaluation and treatment for two times a week for six weeks noting that the injured worker would benefit from physical therapy to strengthen the musculature and reduce the inflammation as a preconditioning prior to a surgical correction. The treating physician noted that the injured worker was on a medication regimen that included Tramadol HCl ER, but did not indicate the specific reason for the requested use of this medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 physical therapy visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Lower Leg (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Pages 98-99.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for sessions of physical therapy. Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. According to the clinical documentation provided and current MTUS guidelines; the documents state the patient completed a course of therapy, and this exacerbated his symptoms. There is no indication for additional therapy if the patient was not improving. Physical therapy is NOT indicated as a medical necessity to the patient at this time.

Tramadol ER 200mg #30: 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, page(s) 75-79.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. There is no clear functional gain that has been documented with this medication. Guidelines state that the discontinuation of opioid medication is recommended if there is no overall improvement in function. According to the clinical documentation provided and current MTUS guidelines; Tramadol is not indicated a medical necessity to the patient at this time.