

Case Number:	CM15-0080547		
Date Assigned:	05/07/2015	Date of Injury:	03/01/2013
Decision Date:	09/23/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/27/2015

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: California
 Certification(s)/Specialty: Emergency 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 65-year-old male patient who sustained an industrial injury on 03/01/2013. A primary treating office visit dated 10/24/2014 reported the patient with subjective complaint of having persistent pain, swelling, tender joint lines and crepitus. He is diagnosed with grade IV chondromalacia tricompartmental, status post arthroscopy 01/2014. The plan of care involve: recommending Synvisc injections to right knee, right knee brace, and continue with current medications Tramadol, Naprosyn and topical Ibuprofen. The patient is temporary totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective physical therapy 2 x 8 for the right hip, DOS: 8/20/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6: Pain, Suffering and the Restoration of Function, page 114; Official Disability Guidelines, Low Back Chapter, Hip and Pelvis Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 58-60 of 127.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not medically necessary

Retrospective physical therapy 2 x 6, DOS: 3/5/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6: Pain, Suffering and the Restoration of Function, page 114; Official Disability Guidelines, Low Back Chapter, Hip and Pelvis Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 58-60 of 127.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not medically necessary.

Retrospective Fluriflex 180gm, DOS: 12/18/13, 3/5/14, 4/16/14, 5/28/14, 7/9/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients, which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of a topical muscle relaxant is stated to be not indicated for use for the patient's condition. The guidelines state the following "Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." As such, the request is not medically necessary.

Retrospective TGHOT 180gm, DOS: 12/18/13, 3/5/14, 4/16/14, 5/28/14, 7/9/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients, which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of gabapentin is stated to be not indicated for use for the patient's condition. The guidelines state the following: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." As such, the request is not medically necessary.

Retrospective Hot/Cold unit, DOS: 12/18/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medline.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

Decision rationale: The request is for the use of hot or cold treatment to be applied topically to aid in pain relief. The ACOEM guidelines under Physical Methods states that during the acute to subacute phase of injury over the first 2 weeks, application of hot or cold can be effective in ameliorating symptoms. This would aid in facilitation of mobility and exercise. Due to the longstanding duration after injury, continued use would not be indicated in this case. As such, the request is not medically necessary.

Retrospective Flurbiprofen powder, Cyclobenzaprine powder, Alba-derm cream, DOS: 5/28/14, 4/25/14, 12/26/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients, which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of cyclobenzaprine is stated to be not indicated for use for the patient's condition. The guidelines state the following: Other muscle relaxants: "There is no evidence for use of any other muscle relaxant as a topical product." As such, the request is not medically necessary.

Retrospective Tramadol HCL powder, Gabapentin powder, Menthol crystals, Camphor crystals, Capsaicin powder, Alba-derm cream, DOS: 5/30/14, 4/25/14, 12/26/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients, which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of gabapentin is stated to be not indicated for use for the patient's condition. As such, the request is not medically necessary.

Retrospective IF unit, DOS: 12/18/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114, Chronic Pain Treatment Guidelines Interferential current stimulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter; National Library of Medicine, State of Colorado Chronic Pain Disorder Medical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential current therapy (IFC).

Decision rationale: The request is for the use of Interferential current therapy (IFC). The MTUS guidelines are silent regarding this issue. The ODG guidelines state the following: Under study for osteoarthritis and recovery post knee surgery. Not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy (IFC) may help reduce pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. (Jarit, 2003) See also the Pain Chapter. A recent industry-sponsored study concluded that interferential current therapy plus patterned muscle stimulation (using the RS-4i Stimulator) has the potential to be a more effective treatment modality than conventional low-current TENS for osteoarthritis of the knee. (Burch, 2008) In this case, the patient does not qualify for the use of this product as it is under study for the recovery post knee surgery. It is not advised for chronic pain. As such, the request is not medically necessary.

Retrospective physical therapy 2 x 6 for the right hip, DOS: 12/18/13, 5/28/14, 7/9/14:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6: Pain, Suffering and the Restoration of Function, page 114; Official Disability Guidelines, Low Back Chapter, Hip and Pelvis Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 & 9792.26 Page(s): 58-60.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not medically necessary.