

Case Number:	CM14-0138947		
Date Assigned:	09/05/2014	Date of Injury:	01/29/2004
Decision Date:	10/14/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	08/27/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54-year-old male who reported an injury on 01/29/2004. The mechanism of injury was not submitted for review. The injured worker has diagnoses of status post left total knee replacement, osteoarthritis localized primary involving the lower leg, sprain of the lumbar region, Chondromalacia of the patella, and internal derangement of the knee. Past medical treatment consists of surgery, physical therapy, and medication therapy. Medications include Vicodin, Norflex, and Voltaren gel. The injured worker has undergone x-rays of the dorsal spine, x-rays of the lumbar spine, and x-rays of the knees bilaterally. On 08/15/2014, the injured worker complained of pain in the knee. Physical examination revealed that the injured worker had right knee medial pain with swelling. There lacked any pertinent evidence of range of motion, muscle strength, or sensory deficits. The treatment plan is for the injured worker to undergo physical therapy to the left knee and the lumbar spine with continuation of medication. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2-3x4 for lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy/Physical Medicine Page(s): 98.

Decision rationale: The request for physical therapy of the lumbar spine is not medically necessary. The California MTUS states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The submitted documentation lacked evidence indicating the progress of prior physical therapy. The efficacy of the therapy was not submitted for review. The guidelines recommend up to 10 visits of physical therapy; the amount of physical therapy visits that have already been completed was not submitted for review. Furthermore, injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. It was not documented that the provider had educated the injured worker on this. Additionally, the request as submitted is for physical therapy 2 to 3 sessions for 4 weeks, which exceeds the recommended guidelines of an initial trial of 10 visits over 4 weeks. In addition, the rationale was not submitted for review. As such, the request for physical therapy of the lumbar spine is not medically necessary.

Voltaren Gel with 2 refills: 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 Topical Analgesics, Page(s): 111-112.

Decision rationale: The request for Voltaren gel is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. Voltaren is not recommended for the use of neuropathic pain, as there is no evidence to support use. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. In the submitted reports, there was no indication as to where the gel would be applied. The request as submitted also did not indicate the duration, the frequency, or the dosage of the medication. Furthermore, there was a lack of quantified evidence of any range of motion, strength, and/or effectiveness of the current medication the injured worker was taking. Given the above and the evidence in the submitted reports, the use Voltaren gel is not recommended. Additionally, the efficacy is questionable and there was no evidence of the injured worker having trialed and failed any antidepressants or anticonvulsants. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Physical Therapy 2-3x4 to the left knee: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Guidelines Physical Therapy ;Physical Medicine Page(s): 98.

Decision rationale: The request for physical therapy to the left knee is not medically necessary. The California MTUS states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The submitted documentation lacked evidence indicating the progress of prior physical therapy. The efficacy of the therapy was not submitted for review. The guidelines recommend up to 10 visits of physical therapy; the amount of physical therapy visits that have already been completed was not submitted for review. Furthermore, injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. It was not documented that the provider had educated the injured worker on this. Additionally, the request as submitted is for physical therapy 2 to 3 sessions for 4 weeks, which exceeds the recommended guidelines of an initial trial of 10 visits over 4 weeks. In addition, the rationale was not submitted for review. As such, the request for physical therapy of the left knee is not medically necessary.