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| Case Number: | CM14-0214622 | | |
| Date Assigned: | 01/07/2015 | Date of Injury: | 08/21/2013 |
| Decision Date: | 02/28/2015 | UR Denial Date: | 11/25/2014 |
| Priority: | Standard | Application Received: | 12/22/2014 |

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. 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: Preventive Medicine, Occupational 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:

Injured worker is a female with date of injury 8/21/2013. Per primary treating physician's progress report dated 12/11/2014, the injured worker complains of cervical spine, left shoulder, bilateral knee, left foot and bilateral lower extremity pain. She rates her cervical pain and left shoulder pain at 9/10 and frequent, bilateral knee pain at 7/10 and frequent. She is taking Tylenol No 3 two tablets a day and reports improvements in her pain level from 9/10 to 4/10 after taking medication. The pain is made better with rest and medications. The pain is made worse with change in weather and activities. She is currently not working. On examination she ambulated and moved around the exam room without difficulty. The left knee is tender medially and laterally. She had crepitus on passive range of motion in the patellofemoral compartment. She was neurologically intact distally. MRA of the right knee showed possible new tear of the medial meniscus. Diagnosis is left knee patellofemoral pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine toxicology screen: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use. Decision based on Non-MTUS Citation Official Disability Guidelines

(ODG), Opioids, screening for tests for risk of addiction and misuse, <http://www.odg-twc.com/odgtwc/pain.htm>

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing section, Opioids Criteria for Use section Page(s): 43, 112.

Decision rationale: The use of urine drug screening is recommended by the MTUS Guidelines, in particular when patients are being prescribed opioid pain medications and there are concerns of abuse, addiction, or poor pain control. The injured worker is prescribed opioid pain medications. The request for urine toxicology screen is determined to be medically necessary.

Tylenol #3 (Codeine 30/Acetaminophen 300) quantity 120: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section Page(s): 74-95.

Decision rationale: The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical documentation indicates that the injured worker has severe pain that is significantly relieved with the use of Tylenol No 3. The requesting physician is also taking measures to assess for aberrant behavior that may necessitate immediate discontinuation of the medications. The injured worker's opioid medication dosing has remained stable and, and she appears to be in a maintenance stage of her pain management. The request for Tylenol #3 (Codeine 30/Acetaminophen 300) quantity 120 is determined to be medically necessary.

Physical Therapy for the right knee; 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical medicine treatment, www.odg-twc.com/odgtwc/pain.htm; Physical therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine section Page(s): 98, 99.

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per

week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified, receive 9-10 visits over 8 weeks. The medical reports indicate that the injured worker has previously had postsurgical physical therapy. The efficacy of this prior therapy and the success of a home exercise program is not reported by the requesting physician. The injured worker would be expected to have a home exercise program for continued self-directed therapy. The need for additional therapy is not explained, and therefore medical necessity has not been established. The request for Physical Therapy for the right knee; 2 times a week for 6 weeks is determined to not be medically necessary.