

Case Number:	CM15-0004327		
Date Assigned:	02/24/2015	Date of Injury:	03/12/2014
Decision Date:	05/26/2015	UR Denial Date:	12/26/2014
Priority:	Standard	Application Received:	01/08/2015

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: Physical Medicine & Rehabilitation

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 28-year-old female with an industrial injury dated 03/12/2013. Her diagnoses include patellofemoral inflammation of the right knee, patellofemoral inflammation of the left knee, and trochanteric bursitis with possible impingement along the right hip. Recent diagnostic testing has included MRI of the right knee (04/15/2014) showing no abnormalities, MRI of the left knee (08/12/2014) showing no abnormalities, and MRI of the right hip (08/12/2014) showing normal findings. Previous treatments have included conservative care, medications, and physical therapy. In a progress note dated 11/25/2014, the treating physician reports pain along the right hip, severe bilateral knee pain. The objective examination revealed swelling to both knees. The treating physician is requesting consultations, medications and durable medication equipment, which were denied by the utilization review. On 12/25/2014, Utilization Review non-certified a request for pain management consultation, noting that the request was made for the injection of the right knee which the requestor was expected to be capable of providing the service. The ACOEM Guidelines were cited. On 12/25/2014, Utilization Review non-certified a request for psychiatrist consultation, noting the mention of some anxiety, depression and anger related to chronic pain with the lack of red flags, no documentation of medication counseling, and no documentation of treatment with medications. The ACOEM Guidelines were cited. On 12/25/2014, Utilization Review non-certified a request for IF or muscle stimulator, noting the absence of a beneficial trial electrostimulation treatment under physical therapy treatment, and no indication of a home exercise program. The MTUS Guidelines were cited. On 12/25/2014, Utilization Review non-certified a prescription for

Protonix 20mg #60, noting there was no indication of upper gastrointestinal (GI) symptoms or diagnoses, and no factors of increasing risk for GI symptoms from medications. The MTUS Guidelines were cited. On 12/25/2014, Utilization Review non-certified a prescription for Flexeril 7.5mg #60, noting there was no documentation of low back pain or muscle spasms, and only short term use recommended. The MTUS Guidelines were cited. On 12/25/2014, Utilization Review non-certified a request for retrospective TENS (Transcutaneous Electrical Nerve Stimulation) pad, noting there was mention of prior use of a TENS unit, but no documented reduction in pain or improved function from its use. The MTUS Guidelines were cited. On 12/25/2014, Utilization Review non-certified a request for TENS unit, noting there was mention of prior use of a TENS unit, but no documented reduction in pain or improved function from its use. The MTUS Guidelines were cited. On 01/08/2015, the injured worker submitted an application for IMR for review of pain management consultation, psychiatrist consultation, IF or muscle stimulator, Protonix 20mg #60, Flexeril 7.5mg #60, retrospective TENS (Transcutaneous Electrical Nerve Stimulation) pad, and a TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management referral/consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee and leg, office visit.

Decision rationale: The request for a pain management referral/consult is not medically necessary. The injured worker reported having persistent knee pain. The injured worker is currently taking Norco for pain. However, per the medical record there is no specific before and after medication pain assessment. The injured worker was prescribed pain medication today, which she has currently been taking. The injured worker also has aqua therapy prescribed and determination success of this treatment is still in question. Therefore, the request is not medically necessary.

Psychiatrist consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines psychological evaluations Page(s): 100.

Decision rationale: The request for a psychiatric consult is not medically necessary. The injured worker reported having anxiety that she is currently taking medication for. There is no documentation that suggests that the medication is not relieving her symptoms. The medical

records do not state any other issues that the injured worker is having that may need to be addressed in regards to a psychiatric consult. Therefore, the request is not medically necessary.

IF or muscle stimulator: 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 Interferential current stimulation Page(s): 118.

Decision rationale: The request for IF or muscle stimulator is not medically necessary. The injured worker complains of persistent knee pain. The improvement of the injured worker while taking prescribed pain medications is not specified on a pain scale to determine how effective the medication is. In order to receive a muscle stimulator the proof of unrelieved pain must be documented. The injured worker states they have good days and bad days therefore the request is not medically necessary.

Protonix 20 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request for protonix 20mg #60 is not medically necessary. There is no documentation of gastrointestinal issues for the injured worker to require the use of protonix. Therefore, the request is not medically necessary.

Flexeril 7.5 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril Page(s): 41.

Decision rationale: The request for flexeril 7.5 mg #60 is not medically necessary. There is no documentation of back pain for the injured worker. The injured worker complains of chronic knee pain. Based on California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain. Medication is for short term use and only primarily in patients with back pain. Therefore, the request is not medically necessary.

Retro TENS pad: 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 criteria for the use of TENS Page(s): 116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee and leg TENS pad.

Decision rationale: The injured worker must have a 30 day trial of a TENS unit in adjunct to consecutive conservative care, in order to purchase a TENS unit with retro pads, there is no documentation that supports this request. Therefore, the request is not medically necessary.

TENS unit: 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 criteria for the use of TENS Page(s): 116.

Decision rationale: The injured worker must have a 30 day trial of a TENS unit in adjunct to consecutive conservative care, in order to purchase a TENS unit. There is no documentation in the medical record that supports this request. Therefore, the request is not medically necessary.