

<b>Case Number:</b>	CM15-0017094		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	01/09/2013
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2015

### 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: New York  
 Certification(s)/Specialty: Neurological Surgery

### 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 56 year old male, who sustained an industrial injury on 1/9/13. The injured worker has complaints of left and right knee pain and right shoulder tenderness. The injured worker favors left lower extremity with ambulation. Limited range of motion with right shoulder and atrophy of the right deltoid musculature; spasm of the cervical trapezius/calf musculature decrease. The diagnoses have included right shoulder rotator cuff tear with chronic impingement; bilateral knee osteoarthopathy and left shoulder status post arthroscopic subacromial decompression. Treatment to date has included status post right shoulder surgery 6/2/14; failed injections, therapy and home exercise. According to the utilization review performed on 1/15/15, the requested left followed by right knee total knee arthroplasty, staged fashion; Post-op Norco 10/325mg, #60; Naproxen 550mg, #60; Post-op home physical therapy 3 x 2; Pre-op history, physical and labs and electrocardiogram (EKG) and assistant has been certified. The requested protonix 20mg#60; Keflex 500mg, #28 and Hydrocodone 10/325mg, #60 has been non-certified. The requested Tramadol 50mg #90 or Tramadol ER 150mg, #30 has been modified to Tramadol ER 150mg #30. The requested Cyclobenzaprine 10mg, #30 has been modified to Cyclobenzaprine 10mg, #20. The requested Physical therapy 3 times a week for 4-6 weeks has been modified to Physical therapy 3 times 4 weeks. CA Chronic Pain MTUS, ACOEM, ODG; MTUS Guidelines opioids; ACOEM Guidelines opioids; MTUS narcotic analgesics; MTUS guidelines failed first line Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) were used in the utilization review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Cyclobenzaprine 10mg, #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics-Cyclobenzaprine Page(s): 64.

**Decision rationale:** According to the California MTUS guidelines Cyclobenzaprine is recommended for a short course of therapy (2-3 weeks). Documentation shows the medication is being prescribed for a longer period. The Guidelines indicate medication should be prescribed at the smallest dose to gain functional effect. The documentation shows the patient had previously been prescribed cyclobenzaprine at the 7.5mg dosage and that was effective. Documentation does not show why the 10 mg dose was selected contrary to guidelines. The requested treatment cyclobenzaprine 10mg, #30 is not medically necessary and appropriate.

### **Hydrocodone 10/325mg, #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids-When to discontinue; on-going management Page(s): 78,79.

**Decision rationale:** The California MTUS guidelines recommend the lowest possible dose be prescribed to improve pain and function. Documentation does not show the program of how this determination was reached. The guidelines recommend weaning when there is no overall improvement in function. The documentation does not indicate when the patient was informed he would be off the opioids and whether his cooperation in such a goal was attained. Thus the requested treatment hydrocodone 10/325 mg, #60 is not medically necessary and appropriate.

### **Protonix 20mg, #60: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medications Chapter-Proton pump inhibitors.

**Decision rationale:** The ODG guidelines do recommend proton pump inhibitors for patients who are at risk for gastrointestinal events. The documentation does not describe recent events. When prescribed according to the guidelines they should be used for the shortest period of time

at the lowest does. Documentation does not provide evidence this guideline was followed. The requested treatment protonix 20 mg, #60 is not medically necessary and appropriate.

**Keflex 500mg, #28:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infectious disease chapter-bone and joint infections.

**Decision rationale:** The ODG guidelines do not recommend providing antibiotics to uninfected wounds. When prophylaxis for surgery is considered, single does close to the time of the operation are recommended. This patient's documentation does not suggest infection. The requested treatment: Keflex 500 mg #28 is not medically necessary and appropriate.

**Associated surgical service: Physical therapy 3 times a week for 4-6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical 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) Knee Chapter-Physical Medicine.

**Decision rationale:** The ODG guidelines recommend for post-surgical treatment for knee arthroplasty 24 visits over 10 weeks. The requested treatment does not meet the guidelines. It requests 18 visits over 4-6 weeks. Thus the requested treatment physical therapy 3 times a week for 4-6 weeks is not medically necessary and appropriate.