

<b>Case Number:</b>	CM15-0128164		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	04/12/2014
<b>Decision Date:</b>	09/24/2015	<b>UR Denial Date:</b>	06/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2015

### 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 54 year old female, who sustained an industrial injury on April 12, 2014. The injured worker was diagnosed as having right knee meniscus tears and chondromalacia. Treatment to date has included medication, Transcutaneous Electrical Nerve Stimulation (TENS), lumbar sacral orthosis (LSO) and physical therapy. A progress note dated May 14, 2015 provides the injured worker complains of right knee pain rated 5/10. She reports gastrointestinal (GI) upset with oral non-steroidal anti-inflammatory drug (NSAID) medication. Physical exam notes mildly antalgic gait with decreased range of motion (ROM) and crepitus. McMurray's sign is positive and there is tenderness on palpation and minimal swelling. The plan includes Transcutaneous Electrical Nerve Stimulation (TENS), physical therapy, lumbar sacral orthosis (LSO), retroactive DOS (5/14/2015) lab work, chiropractic and medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy (right) knee times eight:** Upheld

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

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

**Decision rationale:** Based on the 05/14/15 progress report provided by treating physician, the patient presents with right knee pain. The request is for physical therapy (right) knee times eight. Request for Authorization form dated 06/01/15 includes right knee medial and lateral meniscus tears. The patient presents with mildly antalgic gait. Physical exam to the right knee revealed decreased range of motion (ROM) and crepitus, positive McMurray's. Treatment to date has included medication, Transcutaneous Electrical Nerve Stimulation (TENS), lumbar sacral orthosis (LSO) and physical therapy. Patient's medications include Naproxen, Pantoprazole, Norco and Cyclobenzaprine. The patient is temporarily partially disabled. MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Per 03/28/15 report, treater states "this is a request for extension of window of opportunity to proceed with additional physical therapy right knee, 6 sessions, approved." Given patient's diagnosis and continued symptoms, a short course of physical therapy would be indicated by guidelines. However, the patient has already attended 5 sessions, per 02/24/15 PT notes. Furthermore, treater has not provided explanation of why on-going therapy is needed. There is no discussion of flare-up's or new injury, or why the patient cannot participate in a home exercise program. Moreover, the request for additional 8 sessions would exceed what is allowed by MTUS for the patient's condition. Therefore, the request is not medically necessary.

**Chiro (right) knee times six:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Manual Therapy and Manipulation Page(s): 58, 59.

**Decision rationale:** Based on the 05/14/15 progress report provided by treating physician, the patient presents with right knee pain. The request is for chiro (right) knee times six. Request for Authorization form dated 06/01/15 includes right knee medial and lateral meniscus tears. The patient presents with mildly antalgic gait. Physical exam to the right knee revealed decreased range of motion (ROM) and crepitus, positive McMurray's. Treatment to date has included medication, Transcutaneous Electrical Nerve Stimulation (TENS), lumbar sacral orthosis (LSO) and physical therapy. Patient's medications include Naproxen, Pantoprazole, Norco and Cyclobenzaprine. The patient is temporarily partially disabled. MTUS, Manual Therapy and Manipulation Section, pages 58, 59 state that treatment is "recommended for chronic pain if caused by musculoskeletal conditions: Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2

visits every 4 to 6 months. MTUS page 8 also requires that the treater monitor the treatment progress to determine appropriate course of treatments. Treater does not discuss the request. In this case, MTUS does not recommend chiropractic treatment for the knee. This request is not in accordance with guidelines. Therefore, the request is not medically necessary.

**Hydrocodone 10mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, criteria for use of opioids Page(s): 60, 61, 88, 89, 76-78.

**Decision rationale:** Based on the 05/14/15 progress report provided by treating physician, the patient presents with right knee pain. The request is for Hydrocodone 10MG #60. Request for Authorization form dated 06/01/15 includes right knee medial and lateral meniscus tears. The patient presents with mildly antalgic gait. Physical exam to the right knee revealed decreased range of motion (ROM) and crepitus, positive McMurray's. Treatment to date has included medication, Transcutaneous Electrical Nerve Stimulation (TENS), lumbar sacral orthosis (LSO) and physical therapy. Patient's medications include Naproxen, Pantoprazole, Norco and Cyclobenzaprine. The patient is temporarily partially disabled. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p77 states, "Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." Norco has been included in patient's medications, per progress reports dated 03/28/15, 04/23/15, and 05/14/15. It is not known when this medication was initiated. In this case, treater has not stated how Norco reduces pain and significantly improves patient's activities of daily living. There are no pain scales or validated instruments addressing analgesia. MTUS states that "function should include social, physical, psychological, daily and work activities." There are no specific discussions regarding aberrant behavior, adverse reactions, ADL's, etc. UDS dated 04/07/15 provided with results not consistent with prescribed medications. No opioid pain agreement or CURES reports. No return to work, or change in work status, either. MTUS requires appropriate discussion of the 4A's. Given the lack of documentation as required by guidelines, the request is not medically necessary.

**Retro: Cyclobenzaprine 7.5mg #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for Pain Section Page(s): 64.

**Decision rationale:** Based on the 05/14/15 progress report provided by treating physician, the patient presents with right knee pain. The request is for Cyclobenzaprine 7.5MG #90. Request for Authorization form dated 06/01/15 includes right knee medial and lateral meniscus tears. The patient presents with mildly antalgic gait. Physical exam to the right knee revealed decreased range of motion (ROM) and crepitus, positive McMurray's. Treatment to date has included medication, Transcutaneous Electrical Nerve Stimulation (TENS), lumbar sacral orthosis (LSO) and physical therapy. Patient's medications include Naproxen, Pantoprazole, Norco and Cyclobenzaprine. The patient is temporarily partially disabled. MTUS pg 64, Muscle Relaxants for Pain Section, on Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available) states: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants. (e.g. amitriptyline) This medication is not recommended to be used for longer than 2-3 weeks." Cyclobenzaprine has been included in patient's medications, per progress reports dated 03/28/15, 04/23/15, and 05/14/15. It is not known when this medication was initiated. MTUS recommends Cyclobenzaprine, only for a short period (no more than 2-3 weeks). The patient has been prescribed Cyclobenzaprine for close to 3 months from UR date of 06/25/15. In addition, the request for #90 does not indicate intended short-term use of this medication. This request is not in accordance with guidelines. Therefore, the request is not medically necessary.

**Retro: UDS (DOS 5/14/15):** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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) Pain (Chronic) Chapter, under Urine drug testing (UDT).

**Decision rationale:** Based on the 05/14/15 progress report provided by treating physician, the patient presents with right knee pain. The request is for retro: UDS (DOS 5/14/15). Request for Authorization form dated 06/01/15 includes right knee medial and lateral meniscus tears. The patient presents with mildly antalgic gait. Physical exam to the right knee revealed decreased range of motion (ROM) and crepitus, positive McMurray's. Treatment to date has included medication, Transcutaneous Electrical Nerve Stimulation (TENS), lumbar sacral orthosis (LSO) and physical therapy. Patient's medications include Naproxen, Pantoprazole Norco and Cyclobenzaprine. The patient is temporarily partially disabled. While MTUS Guidelines do not specifically address how frequent UDS should be considered for various risks of opiate users, ODG-TWC Guidelines, Pain (Chronic) Chapter, under Urine drug testing (UDT) Section, provide clear recommendation: "Patients at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Patients at

"moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders." MTUS Chronic Pain Medical Treatment Guidelines, for Testing, pg 43 states: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. Per 05/14/15 report, treater states "three of the six criterion met to fulfill 'high risk' category include historic poor response to opioids, depression (reactive), history of no return to work for some time following injury, high risk once per month testing." In this case, the patient is prescribed Norco, which is an opiate and treater has documented the patient to be 'high risk.' ODG supports UDT "as often as once per month" for "patients at 'high risk' of adverse outcomes." Therefore, this retrospective request is medically necessary.