

<b>Case Number:</b>	CM15-0129852		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	06/24/2014
<b>Decision Date:</b>	08/19/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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: Arizona, Michigan

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:

The injured worker is a 40 year old female who sustained an industrial cumulative trauma injury on 06/24/2014 resulting in right hip pain. Treatment provided to date has included: right hip arthroscopic surgery with labral repair and IT (iliotibial) band release (03/10/2015); unknown number of post-operative physical therapy sessions for the right hip having attended for at least 6 weeks with good improvement in pain, strength and endurance; lumbar epidural steroid injection resulting in 75% improvement; medications; and conservative therapies/care. Diagnostic tests performed include: right hip MRI (2014) showing mild bilateral trochanteric bursitis (right worse than left), moderate gluteus minimus tendonitis on the right (minimal on the left), and a tiny focus of fluid between the acetabulum and labrum. There were no noted comorbidities or other dates of injury noted. On 06/10/2015, physician progress report (PR-2) noted complaints of some continued pain with activities. The injured worker reported that she is still able to walk several blocks. The pain was not rated or described. The injured worker stated that she was still progressing with physical therapy but was not at full strength yet. The injured worker denied having any sleep difficulties. Current medications include Percocet and Ambien. The physical exam revealed full range of motion (ROM) in the lumbar spine, painful ROM of the right hip at 90°, pain with internal and external rotation of the right hip, and some tenderness to palpation over the greater trochanter and anterior aspect of the right hip. There was normal sensation and good distal perfusion throughout the right lower extremity. The provider noted diagnoses of status post right hip arthroscopy with labral repair and IT band release. Plan of care includes continued physical therapy, Voltaren gel to place on the anterior and lateral aspect of the hip,

additional Percocet and Ambien, and follow-up in 6 weeks. The injured worker's work status remained temporarily totally disabled. The request for authorization and IMR (independent medical review) includes: 12 additional sessions of physical therapy for the right hip (2 times a week for 6 weeks), Voltaren gel 1% 4gm quantity 1 with one refill, Percocet 5-325mg #60, and Ambien 10mg #10.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Additional Physical Therapy for the right hip, twice a week for six weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip and Pelvis.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 23.

**Decision rationale:** Per the MTUS guidelines, all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Active physical therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active physical therapy may require supervision from a therapist or medical provider such as verbal, visual or tactile instructions. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement. Physical therapy guidelines allow for fading of treatment frequency from 3 visits per week to 1 visit per week, with a maximum number of allowed visits of 8/10 visits over 4 weeks. Post-surgical guidelines for the hip recommends 18 visits over 12 weeks for osteoarthritis and allied disorders, and 24 visits over 10 weeks for unspecified arthropathy. In this case, a PR-2 dated 04/29/2015, states that the injured worker is 6 weeks post-op right hip arthroscopic surgery with some continued pain in the right groin and with internal rotation. The treatment plan was to continue with physical therapy (request for authorization dated 04/29/2015 is for 12 additional therapy sessions) and follow-up in 6 weeks. The clinical documentation available for review does not clearly indicate how many initial physical therapy sessions were authorized or attended, and it is not clear whether the additional 12 sessions (requested on 04/29/2015) were authorized or attended. Without this information, the request for 12 additional therapy sessions for the right hip, dated 06/10/2015, is not deemed medically necessary. As such, 12 additional physical therapy sessions for the right hip are not medically necessary.

**Voltaren Gel 1% 4gm quantity 1 with one refill: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip and Pelvis.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** According to the MTUS, Voltaren gel is indicated for relief of osteoarthritis pain in joints that are accessible for the application of topical analgesics (ankle, elbow, foot, hand, knee, and wrist). Voltaren has not been evaluated or approved for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The most common adverse reactions were dermatitis and pruritus. The MTUS goes on to state that topical analgesics are largely experimental with few trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trial of antidepressants and anticonvulsants have failed. Topical Non-steroidal anti-inflammatory agents (NSAIDs) like Voltaren have shown to be effective in the treatment of osteoarthritis, but efficacy decreases over the first 2 weeks. Additionally, topical NSAIDs may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Topical NSAIDs may be recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. In this case, the injured worker is 3 months post-op right hip surgery. This medication is not recommended or approved for the treatment of the spine, hip or shoulder. As such, the requested Voltaren gel 1% is not medically necessary.

**Percocet 5/325mg quantity 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 Page(s): 74-96.

**Decision rationale:** Percocet (Oxycodone/acetaminophen) contains a narcotic (opioid) pain reliever and is used to treat moderate to moderately severe pain. MTUS discourages long-term usage of opioids unless there is evidence of "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The MTUS also recommends the discontinuation of Oxycodone (an opioid) when there is no overall improvement in function, unless there are extenuating circumstances. Weaning should occur under direct ongoing medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. Upon review of the submitted documentation, the treating physician does not document: 1) the least reported pain over the period since last assessment; 2) average pain; 3) intensity of pain after taking the opioid; 4) how long it takes for pain relief; 5) how long pain relief lasts; 6) improvement in pain; or 7) improvement in function. In addition, there was no indication of the severity of injured worker's pain, and there has been no overall measurable improvement in function or decrease in pain while taking this medication. As such, Percocet 5-325mg #60 is not medically necessary.

**Ambien 10mg quantity 10:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Ambien.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (chronic) chapter - Zolpidem (Ambien) and Insomnia Treatment; and Mental Illness & Stress Chapter - Zolpidem (Ambien) and Insomnia Treatment.

**Decision rationale:** The MTUS (Medical Treatment Utilization Schedule) is silent in regards to the use of Ambien (Zolpidem); therefore, alternative guidelines were consulted in the review and decision of this medication. The ODG states: "Recommend that treatment be based on the etiology, with the medications recommended below. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness." The ODG recommends Ambien, a short-acting non-benzodiazepine hypnotic, for the short-term (7-10 days) treatment of insomnia. This medication is not recommended for long-term use as it can be habit-forming, and may impair function and memory more than opioid pain relievers. "There is also concern that it may increase pain and depression over the long-term." In this case, there are no ongoing complaints of insomnia. Additionally, it was not indicated how long the injured worker has been taking this medication and this medication is not recommended for long-term use (longer than 7-10 days). As such, the request for Ambien 10mg #10 is not medically necessary.