

Case Number:	CM15-0073403		
Date Assigned:	04/27/2015	Date of Injury:	03/10/2010
Decision Date:	06/26/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/17/2015

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, Pain Management

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 58-year-old female who sustained an industrial injury on 3/10/10. The injured worker reported symptoms in the back and lower extremities. The injured worker was diagnosed as having L4-5 severe disc degeneration, L4-5 stenosis, bilateral leg radiculopathy with right L3 and L4 motor and sensory changes, status post right L4-5 laminotomy, mesial facetectomy and foraminotomy and bilateral greater trochanter bursitis. Treatments to date have included nonsteroidal anti-inflammatory drugs, oral pain medication, and activity modification. Currently, the injured worker complains of pain in the low back with radiation to the lower extremities. The plan of care was for physical therapy, right knee corticosteroid injection, medication prescriptions and a follow up appointment at a later date.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 sessions of physical therapy for the right knee and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98-99 of 127. Decision based on Non-MTUS Citation ODG, Low Back and Knee Chapters, Physical Medicine.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested physical therapy is not medically necessary.

Corticosteroid injection for the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation x Official Disability Guidelines (ODG), Knee and Leg Chapter, Corticosteroid injections.

Decision rationale: Regarding the request for a knee corticosteroid injection, CA MTUS cites that invasive techniques, such as needle aspiration of effusions or prepatellar bursal fluid and cortisone injections, are not routinely indicated. ODG states that intra-articular corticosteroid injections are recommended for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. The beneficial effect could last for 3 to 4 weeks, but is unlikely to continue beyond that. The criteria for intra-articular glucocorticosteroid injections, according to the American College of Rheumatology (ACR), states that there has to be documentation of 1) severe osteoarthritis of the knee with knee pain. 2) Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen). 3) Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease. 4) Intended for short-term control of symptoms to resume conservative medical management or delay TKA. Guidelines go on to state that a second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; with several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; the number of injections should be limited to three. Within the documentation available for review, the criteria outlined above have not been met and no other clear rationale for the injection has been presented. As such, the currently requested knee corticosteroid injection is not medically necessary.

Tylenol no. 3 #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Tylenol #3, California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS). Furthermore, it appears that the patient is concurrently utilizing another short-acting opioid, which is redundant. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Tylenol #3 is not medically necessary.

Motrin 800mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 67-72 of 127.

Decision rationale: Regarding the request for Motrin, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Motrin is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale) or any objective functional improvement. In the absence of such documentation, the currently requested Motrin is not medically necessary.