

Case Number:	CM15-0092746		
Date Assigned:	05/19/2015	Date of Injury:	03/29/1999
Decision Date:	07/07/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	05/13/2015

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: Florida
 Certification(s)/Specialty: Family Practice

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 59-year-old female who sustained an industrial injury on 03/29/1999. Mechanism of injury was not provided. The injured worker stopped working in 2008. Diagnoses include internal derangement of her bilateral knees, status post bilateral knee joint replacements, chronic pain, depression, insomnia, and stress. Prior surgeries include right knee surgery in 1998, back surgery in 2010, and bilateral total knee arthroplasty, right in 2008, and left in 2010. Treatment to date has included diagnostic studies, medications, surgery, aqua therapy, gym membership, home exercise program and a Transcutaneous Electrical Nerve Stimulation unit. Diagnostic studies were not provided with documentation. A physician progress note dated 04/02/2015 documents the injured worker complains of right knee buckling and there is a sense of some instability, and there is tenderness along the knees. She ambulates with a limp. She has 180 degrees of extension and 95 degrees of flexion with a grade 5- strength to resisted function. She has mild anterior and posterior instability and laxity with varus and valgus being noted. The treatment plan included Tylenol #3 # 30, Nalfon 400mg #60, Protonix 20mg #60, Trazodone 50mg #60, Naproxen 550mg #60, Norflex 100mg extended release #60, and conductive garment with Transcutaneous Electrical Nerve Stimulation unit. Treatment requested is for Conductive Garment for Use with TENS Unit, IF or Muscle Stimulator Unit, Norflex 100 MG Extended Release Qty 60, Protonix 20 MG Qty 60, and Tylenol #3 Qty 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF or Muscle Stimulator Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) MTUS, pg 127 Page(s): 127.

Decision rationale: MTUS guidelines state regarding Interferential current stimulation, "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. Regarding this patient's case, there is no documentation of benefit with prior usage of this device under the instruction of a licensed physical therapist or physician. MTUS guidelines have not been satisfied. Likewise, this request for an IF unit is not considered medically necessary.

Conductive Garment for Use with TENS Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain medical treatment guidelines, TENS unit, 114-117 Page(s): 114-117.

Decision rationale: A conductive garment for use with a TENS unit is being requested. However, no documentation has been provided regarding decreased pain and functional improvement with prior TENS unit usage. Likewise, this request for a conductive garment IS NOT medically necessary without additional documentation.

Protonix 20 MG Qty 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): 68-69 of 127..

Decision rationale: In accordance with California MTUS guidelines, PPI's (Proton Pump Inhibitors) can be utilized if the patient is concomitantly on NSAIDS and if the patient has gastrointestinal risk factors. Whether the patient has cardiovascular risk factors that would contraindicate certain NSAID, use should also be considered. The guidelines state, "Recommend with precautions as indicated. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." This patient does not have any of these gastrointestinal or cardiovascular risk factors. Likewise, this request for Protonix is not medically necessary.

Norflex 100 MG Extended Release Qty 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 100, 97.

Decision rationale: In accordance with the California MTUS guidelines, Norflex is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS guidelines: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence." Likewise, this request for Norflex is not medically necessary.

Tylenol #3 Qty 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): page(s) 76-80 of 127.

Decision rationale: In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if: "(a) If the patient has returned to work; (b) If the patient has improved functioning and pain." MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is no objective evidence of functional improvement. Likewise, this requested chronic narcotic pain medication is not considered medically necessary.