

## Independent Medical Review Final Determination Letter

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[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/30/2013

<b>IMR Case Number:</b>	CM13-0017958	<b>Date of Injury:</b>	03/16/2000
<b>Claims Number:</b>	[REDACTED]	<b>UR Denial Date:</b>	08/12/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/28/2013
<b>Employee Name:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED] M.D.		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
PLEASE REFERENCE UTILIZATION REVIEW DETERMINATION LETTER			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]  
[REDACTED]

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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/services.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 3/16/2000. This patient is a 46-year-old man. He has a complex medical history including lumbar discopathy, status post lumbar spine hardware removal and prior fusion at L4 through S1 and prior microdiscectomy, status post lumbar microdiscectomy, status post left knee arthroscopy, status post right knee arthroscopy, right knee tendinosis, right knee lateral meniscus tear, and a lumbar bulge. Treating physician notes as of July 31, 2013 note that the patient at that time complained that he took a step and his knee gave away and he twisted his right ankle. The patient reported ongoing low back and bilateral knee symptoms. At that time the patient was treated with Toradol and vitamin B complex. The patient's detailed diagnoses were reviewed. The treating physician felt at that time the patient needed MRI scans of both knees and a trial of extracorporeal shock wave therapy and that the patient might need a total knee arthroplasty in the future. He felt the patient's use of Norco had been effective because it allowed the patient to perform some activities of daily living. He noted that the patient's use of Norco had caused some gastrointestinal upset and therefore he prescribed Ranitidine. An initial physician review noted that the patient had undergone urine drug testing on 6/5/2013 and that the provider had not assessed the results of that screen and therefore an additional screen was not necessary. He noted that for nontraumatic knee pain the guidelines did not support knee injections. The prior reviewer modified a request for hydrocodone to allow for a taper and discontinuation. A prior review indicated there was not an indication for topical analgesics. Also, a prior reviewer indicated that additional information would be necessary in order to render a decision regarding steroid injection, including documentation of prior trials of injection therapy. Similarly the reviewer felt that additional information would be needed in order to determine a decision regarding Synvisc.

## IMR DECISION(S) AND RATIONALE(S)

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

### **1. One Urine Drug Screen is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, section on Drug Testing page 43, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines section on drug testing states "Recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs." The medical records provided for review indicate that the employee previously underwent urine drug screening, but overall there is limited documentation or discussion regarding past drug screening results and the overall risk of aberrant behavior. In this setting, the medical records do not support a repeat urine drug screen. **The request for one urine drug screen is not medically necessary and appropriate.**

### **2. X-Ray of the bilateral knee, standing AP is not medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 13 (knee Complaints) (2004) page 343, which is part of the MTUS, and the Official Disability Guidelines, Knee & Leg (Acute & Chronic) section, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Knee Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 13) page 343, which is part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM Guidelines, Chapter 13, Knee, Page 343 states "Reliance only on imaging studies to evaluate the source of these symptoms may carry a significant risk of diagnostic confusion." According to the medical records provided for review, this is a complex case with extensive diagnostic studies which have been performed previously. The rationale for additional plain films of the knees at this time is not apparent from the medical records. **The request for X-Ray of the bilateral knee, standing AP is not medically necessary and appropriate.**

### **3. Hydrocodone/APAP 10/325mg #60 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Opioids page 78, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines section on Opioids Ongoing Management recommends "Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects." The medical records provided for review contain only limited information regarding the overall functional benefit of opioids and plan for long-term use, particularly given the reported gastrointestinal side effects of this medication and substantial other risks of long-term side effects. **The request for Hydrocodone/APAP 10/325MG #60 is not medically necessary and appropriate.**

**4. Flurbiprofen/Cyclobenzaprine 10/10% cream 180 gm is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Topical Analgesics page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines section on Topical Analgesics recommends "The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required . . . Other muscle relaxants "There is no evidence for the use of any other muscle relaxants as a topical product." Thus, the guidelines in general do not support the use of a topical agent given the limited information in this case. The guidelines also specifically do not recommend the use of cyclobenzaprine topically. **The request for Flurbiprofen/Cyclobenzaprine 10/10% cream 180 gm is not medically necessary and appropriate.**

**5. Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/2/0.05% topical cream 180 mg is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Topical Analgesics page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines section on Topical Analgesics states that "the use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required . . .

Gabapentin: Not recommended. There is no peer reviewed literature to support its use . . . Capsaicin: Recommended only as an option in patients who have not responded to or are intolerant to other treatments.” The treatment guidelines therefore in general do not support an indication for topical analgesics in this case. The guidelines additionally, specifically do not support the component medications gabapentin and capsaicin. **The request for Tramadol/Gabapentin/Menthol/Camphor/Capsaicin 8/10/2/2/0.05% topical cream 180 mg is not medically necessary and appropriate.**

**6. Error! Reference source not found.is not medically necessary and appropriate.**

The claims administrator did not cite any evidence based criteria for its decision

The Physician Reviewer based his/her decision on the Knee Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 13) page 339, which is part of the MTUS, and the Official Disability Guidelines Knee section, which is not part of the MTUS.

The Physician Reviewer’s decision rationale:

ACOEM Guidelines Chapter 13 Page 339 states “Invasive techniques, such as needle aspiration or cortisone injections are not routinely indicated.” Additionally, the Official Disability Guidelines state hyaluronic acid injections are indicated for patients who “Experience significantly symptomatic osteoarthritis but have not responded adequately to standard nonpharmacological and pharmacological therapies.” At this time there has been a request simultaneously for both steroid injection and Synvisc injection to the right knee. Either of these treatments would require substantial documentation of the medical history and goals and clinical rationale beyond what is documented in the medical records provided for review. Moreover, the guidelines would not support simultaneous steroid and Synvisc injections and therefore clarification would be needed as to which of these injections is desired and the rationale for that request. **The request for 1 right knee injection of 6cc of Lidocaine and 1cc of Celestone is not medically necessary and appropriate.**

**7. 1 Synvisc Injection to the right knee is not medically necessary and appropriate.**

The claims administrator did not cite any evidence based criteria for its decision

The Physician Reviewer based his/her decision on the Knee Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 13) page 339, which is part of the MTUS, and the Official Disability Guidelines Knee section, which is not part of the MTUS.

The Physician Reviewer’s decision rationale:

ACOEM Guidelines Chapter 13 Page 339 states “Invasive techniques, such as needle aspiration or cortisone injections are not routinely indicated.” Additionally, the Official Disability Guidelines state hyaluronic acid injections are indicated for patients who “Experience significantly symptomatic osteoarthritis but have not responded adequately

to standard nonpharmacological and pharmacological therapies.” At this time there has been a request simultaneously for both steroid injection and Synvisc injection to the right knee. Either of these treatments would require substantial documentation of the medical history and goals and clinical rationale beyond what is documented in the medical records provided for review. Moreover, the guidelines would not support simultaneous steroid and Synvisc injections and therefore clarification would be needed as to which of these injections is desired and the rationale for that request. **The request for 1 Synvisc injection to the right knee is not medically necessary and appropriate.**

/MCC

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient’s physician. MAXIMUS is not liable for any consequences arising from these decisions.

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CM13-0017958