

Case Number:	CM13-0013187		
Date Assigned:	09/25/2013	Date of Injury:	01/11/2003
Decision Date:	01/22/2014	UR Denial Date:	07/22/2013
Priority:	Standard	Application Received:	08/16/2013

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 Orthopedic Surgery 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 33-year-old gentleman who was injured in a work-related accident on 01/11/03. Clinical records for review include a recent assessment of 07/01/13 with treating physician, [REDACTED] where he was noted to be with subjective complaints of pain about the knee on the left and the right, anterior in nature on the left and posterior on the right. Objectively, the left knee was noted to be with palpable edema at the distal aspect of the previous scar with tenderness noted diffusely. The right knee was also with diffuse tenderness and quadriceps weakness, positive crepitation, positive apprehension, and diminished range of motion. Working diagnoses were the following: 1. Status post open reduction internal fixation of the left tibia with retained hardware, December 2003; 2. Status post left knee removal of hardware, November 2009; 3. Mechanical low back pain; 4. Lumbar disc radiculopathy; 5. Left lower extremity reflex sympathetic dystrophy; and 6. Right knee internal derangement. Previous imaging to the claimant's knees is not noted. At present, there is a request for a left knee radiograph and medications in the form of Prilosec, topical Ketoprofen, topical Flurbiprofen, and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray of the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: Knee Procedure - Radiography and Indications for Imaging - X-rays.

Decision rationale: California MTUS Guidelines do not address imaging in the chronic setting but do address it in the acute setting as appropriate after trauma. When looking at Official Disability Guidelines criteria, plain film radiographs of the left knee would not be indicated. Radiographs of the knee are indicated for acute assessment of traumatic injury as well as non-traumatic knee pain on initial evaluations. Records in this case indicate that the claimant has a long history of injury to the left knee, dating back to the open reduction internal fixation of the tibia in 2003. It is also noted that the hardware was removed in 2009. At present, it would be unclear as what a plain film radiograph would add to the claimant's current course of clinical care, for which he has been on chronic medication management and for which there is no documentation of significant change on examination at present. This specific request for the radiograph of the knee is not indicated.

Prilosec 20mg #60, with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

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

Decision rationale: Based on MTUS Chronic Pain Guidelines, the use of Prilosec would not be supported. Records at present fail to demonstrate the claimant to be at significant risk for a gastrointestinal event associated with the use of current medications. The claimant also does not demonstrate any GI risk factors that put him at need for Prilosec, a proton pump inhibitor. Guideline criteria indicate the role of GI risk factors, which would include an age greater than 65 years, history of peptic ulcer, GI bleeding, or perforation, concordant use of aspirin, corticosteroid or anticoagulant, or use of high doses of multiple nonsteroidal medications. The absence of the above indications would fail to necessitate continued use of Prilosec at present.

Flurbiprofen 10%/25%/2% - #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

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

Decision rationale: Based on California MTUS Chronic Pain Medical Treatment Guidelines, any topical agent that contains Flurbiprofen also would not be supported. California MTUS Guidelines clearly indicate that topical, compounded agents are largely experimental and that they are used with few randomized clinical trials determining their efficacy or safety. Currently,

the FDA only approves the use of Diclofenac as an anti-inflammatory agent for use in a topical application. As Flurbiprofen is not FDA approved for topical use, the request is not considered medically necessary.

Ketoprofen 10%/3%/5% - #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics/Ketoprofen Page(s): 112.

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

Decision rationale: Based on California MTUS Chronic Pain Medical Treatment Guidelines, any topical agent that includes Ketoprofen would not be supported. Guidelines specifically state Ketoprofen is a non-FDA approved agent for use in a topical application, as it has been known to have an extremely high occurrence of photo-contact dermatitis. As the requested topical contains a non-FDA approved medication it cannot be recommended as medically necessary.

Norco 10/325mg #60, with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Ongoing Management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids - Criteria for Use Page(s): 76-80.

Decision rationale: Continued use of Norco in this case does appear to be medically necessary. MTUS Guidelines in regard to chronic use of narcotic agents indicates the demonstration of continued efficacy in pain relief as well as continued improvements in overall function and progress should be noted. Records indicate the claimant is with complex history in regard to his lower extremities and low back, including the current diagnosis of reflex sympathetic dystrophy. The continued role of this short acting analgesic for symptomatic relief of the claimant's ongoing and chronic diagnosis would appear to be medically necessary at present.