MAXIMUS Federal Services

Case Number:	CM13-0028172		
Date Assigned:	11/22/2013	Date of Injury:	06/13/2013
Decision Date:	02/04/2014	UR Denial Date:	09/18/2013
Priority:	Standard	Application Received:	09/23/2013

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 Physical Medicine and Rehabilitation, and is licensed to practice in Maryland. 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:

This is a 51 year-old male with a 6/13/13 date of injury sustained by his left knee from a fall. Specifically, he reports he had to jump off a lift gate which was not working. When he landed, he felt his left knee twist. He did not fall to the ground, though he felt knee pain. Diagnostics; 7/30/13 Magnetic Resonance Imaging (MRI) of the left knee impression: Slight blunting of the meniscal apex Involving the posterior horn of the lateral meniscus with intrameniscal signal seen extending to the superior articular surface. These findings are compatible with a lateral meniscal tear. Mild thinning and irregularity involving a portion of the articular cartilage of the posterior weight bearing surface of the lateral tibial plateau.1 cm subchondral cyst seen within the lateral tibial plateau adjacent to the lateral tibial spine. Bone fragment seen adjacent to the superomedial aspect at the patella with a pseudoarthrosis. Differential diagnosis includes an unusual presentation for a bipartite patella very old fracture fragment with nonunion, or an area of heterotopic ossification.11/14/13: Patient is s/p: 1. Left knee arthroscopic partial medial and lateral meniscectomy.2. Left knee medial and lateral compartment synovectomy.3. Removal of left knee loose bodies. 9/11/13 progress note states that the patient continues to have pain in his knee especially in the medial aspect He notes that the patient benefits from the medication however, complains of gastritis type symptoms. The patient is noted to be on Norco but is willing to be managed without narcotic medications. Patient currently smokes half a pack of cigarettes per week. Patient has been sober from addiction to speed which was fifteen years ago. He denies alcohol or IV drug us. Examination revealed swelling of the left knee. The left knee ROM was decreased. There is tenderness over medial aspect of the left knee along the joint line with spasms and trigger points in the left quadriceps. There is decreased sensation glo

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg BID: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Naproxen 550mg BID is medically necessary per California Medical Treatment Utilization Schedule Guidelines (MTUS) guidelines. Guidelines state: "Anti inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. (Van Tulder-Cochrane, 2000)." Patient is receiving benefit from the Naproxen. He wishes to discontinue Norco. Naproxen is medically appropriate.

Omeprazole 20mg QD: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: Per California Medical Treatment Utilization Schedule Guidelines (MTUS) guidelines, Omeprazole 20mg daily is not medically necessary. Per Official Disability Guidelines (ODG), "Studies suggest, however, that nearly half of all proton pump inhibitor prescriptions are used for unapproved indications or no indications at all." The 9/11/13 progress note indicates patient has "gastritis type symptoms" Gastroesophageal (GERD) was also documented. There is no history that patient meets California Medical Treatment Utilization Schedule Guidelines (MTUS) criteria for a proton pump inhibitor incuding : Factors that a relacking to meet this criteria include age, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of acetylsalicylic acid, corticosteroids, and/or an anticoagulant, high dose/multiple Nonsteroidal anti-inflammatory drug (NSAID) (e.g., NSAID + low-dose acetylsalicylic acid). California Medical Treatment Utilization Schedule Chronic Pain Guidelines do not support treatment proton pump inhibitor medication in the absence of symptoms or risk factors for gastrointestinal disorders. Patient has no documentation of a peptic ulcer, gastrointestinal bleed or perforation.Furthermore, he is not on concurrent use of acetylsalicylic acid, corticosteroids and/oranticoagulation or multiple Nonsteroidal anti-inflammatory drugs (NSAIDs). Additionally, per Official Disability Guidelines (ODG) guideline: In general, the use of a proton pump inhibitor should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. proton pump inhibitors are highly effective for their approved indications, including preventing gastric ulcers induced by Nonsteroidal anti-inflammatory drugs (NSAIDs). Studies suggest, however, that nearly half of all proton pump inhibitor prescriptions are used for unapproved indications or no indications at all.

Urine toxicology screen: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: My rationale for why the requested treatment/service is or is not medically necessary: Urine toxicology screen is medically appropriate in this patient per California Medical Treatment Utilization Schedule (MTUS) guidelines. Per guidelines random urine toxicology screens are an appropriate measure in patients with high risk of abuse. Patient has a risk of abuse in the past and therefore it is reasonable to monitor a urine toxicology screen. Patient was on Norco . This medication was discontinued 9/11/13 office visit. It was reasonable to order this urine toxicology screen at the 9/11/13 office visit as patient had been taking this medication.

Electromyogram (EMG) and Nerve Conduction Studies for left lower extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM.

Decision rationale: Electromyogram (EMG) and Nerve Conduction Studies for left lower extremity is medically appropriate. Electrodiagnostics were requested to rule out peripheral neuropathy versus lumbosacral radiculopathy. Patient has decreased sensation globally on the left knee to light touch and additionally deficits in Strength-There is decreased knee strength in flexion and extension 4/5. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) indicates the following: "Peripheral nerve entrapment may be manifested as foot drop if the peroneal nerve at the knee is involved or, rarely, as a tarsal tunnel syndrome, presenting as numbness of the plantar surface of the foot and toes. Foot drop also can be seen in L5 neuropathy due to an L4-5 disc protrusion." Although foot drop is not described in the submitted documentation the deficits in sensation and knee strength in extension may be secondary to nerve entrapment around the knee (i.e. peroneal neuropathy at the fibular head) and it is reasonable to evaluate for this. Additionally the decrease in knee flexion may be secondary to lumbar radiculopathy affecting the S1 myotomes. Additonally per American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), "Likewise, sciatic or femoral nerve irritation or hip disease can cause knee symptoms." It is not unreasonable to ensure that patient is not having referred pain from his back to his knee. These symptoms can occur with lumbar radiculopathy after a fall similar to the one that occurred with his injury.