

Case Number:	CM13-0033917		
Date Assigned:	02/05/2014	Date of Injury:	10/30/2008
Decision Date:	04/23/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	10/11/2013

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. The expert 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 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/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 57 year old male who was injured on 10/30/2008 while he was walking backwards; the plywood had been removed from a 5 feet hole so ended up falling into the hole. Prior treatment history has included a prior arthroscopy on the right knee, which was successful in alleviating a significant portion of his symptoms. UR report dated 09/09/2013 indicated pre-op clearance to include history and physical, CBC, CMP, and EKG is certified as well as 1 pair of crutches. The patient has been approved for left knee arthroscopy and meniscectomy for reported positive examination and MRI findings of a meniscal tear. Follow up note dated 09/06/2013 documented the patient is going for massage treatments. He does have access to knee braces, the collar with gel, the neck pillow, the latter is flattened. He does have a TENS unit. He still has element of depression, GI irritation, GERD, and hearing loss. HE IS ALLERGIC TO AMOXICILLIN. He has no hypertension or diabetes. He has issue with sleep, depression, and stress. Objective findings on exam revealed tenderness along the joint line. The patient was diagnosed with internal derangement of the knee on the right status post meniscectomy on the right knee. The patient has element of depression and sleep. The patient has GI irritation. The treatment and plan is to get him ready for the surgery. He is not doing well with the Norco. I gave him OxyContin 10 mg. I would like him not to be on Valium, but I did agree with one more refill. He was approved for Tramadol ER 150 mg, Effexor SR 75mg, Prilosec 20 mg, trazodone 50 mg. Liver and kidney tests will be done in preparation for surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 ELS ROM: 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 ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG).

Decision rationale: The patient is to undergo arthroscopic meniscal repair of the left knee. Appropriate postoperative measures would include access to crutches, a brief course of supervised physical therapy with instruction in a home exercise program, and medication to address postoperative pain. However, the request for an ELS (extension lock splint) is not supported in this post-operative setting. According to the referenced guidelines, studies reveal postoperative bracing protect against re-injury, decrease pain, or improve stability. Mobility should be favored over immobilization. There does not appear to be a viable rationale for the request of ELS ROM., consequently medical necessity of this request has not been established.

1 PAIN CATHETER: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, POST-OPERATIVE PAIN PUMP

Decision rationale: According to the guidelines, postoperative pain pumps are not recommended. There is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. The use of this device for arthroscopic knee procedure is not supported by the guidelines. The patient would be able to manage pain with judicious use of standard oral medications and palliative measures of ice/heat. As this request is not consistent with evidence-based guidelines, the medical necessity is unsubstantiated.

1 PRE-OP CHEST XRAY: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK, PREOPERATIVE

Decision rationale: The Expert Reviewer's decision rationale: The patient is to undergo meniscectomy, which is a relatively routine and simple arthroscopic procedure. According to the Official Disability Guidelines, preoperative additional tests are excessively ordered. The tests are not good standardized screening instruments for diseases. "The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings." In the absence of any significant and relevant comorbidities evident by the patient's history and/or physical examination, the medical necessity of a preoperative chest x-ray is not established.

1 PRESCRIPTION OF AMOXICILLIN 875MG #20: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: AMOXICILLIN; MEDLINE PLUS

Decision rationale: According to the medical literature, Amoxicillin is used to treat certain infections caused by bacteria, such as pneumonia; bronchitis; gonorrhea; and infections of the ears, nose, throat, urinary tract, and skin. It is in a class of medications called penicillin-like antibiotics. According to the 09/06/2013 follow-up report, patient is allergic to amoxicillin. Given the known medication allergy, providing the patient with this medication is grossly inappropriate and would not be recommended.

1 PRESCRIPTION OF ZOFRAN 8MG #20: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, ANTIEMETICS (FOR OPIOID NAUSEA)

Decision rationale: According to the guidelines, Zofran is not recommended for nausea and vomiting secondary to chronic opioid use. It is only recommended for acute use, under FDA approval, in addressing nausea and vomiting secondary to chemotherapy and radiation treatment, for postoperative use, and for gastroenteritis. It is acknowledged that the patient is pending meniscectomy. There was no evidence in the medical records to establish the patient will have significant issues with nausea post-surgery. The medical necessity of this medication has not been established in this case.

NEURONTIN 600MG #20: Upheld

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

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

Decision rationale: According to the CA MTUS guidelines, Anti-epilepsy drugs are recommended for neuropathic pain (pain due to nerve damage). Neurontin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. However, the medical records document the patient does not have diabetes, and there is no indication of postherpetic neuralgia. Additionally, the medical records do not document specific subjective complaints, correlating clinical findings that substantiate an active neuropathy. As a neuropathic pain condition is not evident, the medical necessity for Neurontin is not established.

1 POLAR CARE: Overturned

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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) KNEE

Decision rationale: The Expert Reviewer's decision rationale: The patient is pending left knee surgery. According to the Official Disability Guidelines, Continuous-flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. Since the patient is to undergo knee surgery, rental of a cryotherapy device, of up to 7 days, is medically appropriate and supported by the guidelines.

REJUVENESS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

Decision rationale: As stated, the patient is to undergo arthroscopic meniscal repair of the left knee. Appropriate postoperative measures would include access to crutches, a brief course of supervised physical therapy with instruction in a home exercise program, and judicious use of medication to address postoperative pain. The medical records do not document a viable rationale for the request of Rejuveness. The guidelines note the role of the clinician is to provide an appropriate treatment plan and adhere to a conservative evidence-based treatment approach. The purpose of this product and how it is expected to impact the patient's postoperative course is

not provided. Of note, an internet [REDACTED] search of the name, indicates it is a line of topical scar reduction products or anti-aging/wrinkle creams. Consequently, products for aesthetic benefits are not supported by the guidelines. Consequently medical necessity of this request has not been established, and would not be recommended.