

Case Number:	CM14-0009977		
Date Assigned:	02/21/2014	Date of Injury:	01/29/2009
Decision Date:	08/06/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/24/2014

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 Occupational Medicine, 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 71-year-old male who has submitted a claim for recurrent dislocation of ankle and foot, and contusion of foot, associated with an industrial injury date of January 29, 2009. Medical records from 2013 through 2014 were reviewed. The latest progress report, dated 12/17/13, showed increased pain in the right ankle, right lower extremity, and right foot. Physical examination revealed no limitation in flexion, extension, internal rotation or external rotation. The right knee was stable to both valgus and varus stress in extension. Other tests were negative such as Lachman's, pivot, posterior drawer, and reverse pivot. No joint effusion was noted. Patellar apprehension test, patellar grind test, ballotable patella sign were all negative. Patellar mobility test showed normal translation. Inspection of the foot revealed no swelling, no deformity, nodules, corns, calluses, or flat foot deformity. Range of motion was normal in inversion, eversion, flexion and extension at all the joints of the right foot. No pain was noted during inversion, eversion, flexion or extension at all the joints of the right foot. No tenderness was noted. Treatment to date has included right knee arthroscopy with partial medial and lateral meniscectomies and chondroplasty of multiple compartments, with evidence for chondromalacia (2009), total knee replacement (2013), visco supplementation of right knee, 8 sessions of postoperative physical therapy completed since July 2013, and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

COMPOUND TRANSDERMAL ANALGESIC CREAM, GABAPENTIN 10% 30 GM AND CYCLOBENZAPRINE 10 % 30 GM, APPLY TO AFFECTED AREA TWICE PER DAY, FOR RIGHT KNEE AND RIGHT FOOT PAIN.: Upheld

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

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

Decision rationale: As noted on pages 111-113 in the California MTUS Chronic Pain Medical Treatment Guidelines, the use of gabapentin is not supported as topical formulation. Cyclobenzaprine is not recommended for use as a topical analgesic. In this case, compounded products were prescribed as adjuvant therapy for oral medications. However, there is no discussion concerning the need for 2 different topical medications. In addition, components of this compound, i.e., cyclobenzaprine and gabapentin, are not recommended for topical use. The guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, the request is not medically necessary.

4 ADDITIONAL PHYSICAL THERAPY FOR THE RIGHT KNEE 1 TIME PER WEEK FOR 4 WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: According to pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition, guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, the patient completed 8 sessions of postoperative physical therapy since July 2013. The rationale for requesting additional physical therapy is to address the right knee for lumbar radicular pain and to improve his gait endurance. However, the recent progress report revealed no limitation in the range of motion for the right knee, no weakness, no sensory deficit, and no instability. The medical necessity was not established since there is no sufficient objective evidence of musculoskeletal deficit. Therefore, the request is not medically necessary.