

Case Number:	CM14-0012457		
Date Assigned:	02/21/2014	Date of Injury:	02/23/2009
Decision Date:	08/12/2014	UR Denial Date:	01/08/2014
Priority:	Standard	Application Received:	01/30/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

This is a 40 year old female with a 2/23/2009 date of injury. A specific mechanism of injury was not described. The injured worker is status post right arthroscopy on 2/21/13. A 1/8/14 determination was modified. There was a certification for a re-evaluation with an orthopedic surgeon and non-certification was rendered for a knee sleeve and Voltaren cream. Reasons for non-certification included no previous arthroplasties, intraarticular fractures, ligament injury, or severe instability for which a knee sleeve would be indicated. Regarding Voltaren cream there was no indication of failure of oral NSAIDs. A 1/8/14 medical report identifies left knee pain. Severity of knee pain is moderate to severe. On exam there was tenderness over the medial aspect. McMurray's, Lachman's, varus/valgus stress tests, and instability are negative. A 12/4/13 medical report identifies bilateral wrist pain. The left knee and upper back bothered the patient, but she was improving. Left knee was tender at the joint line. An 11/6/13 medical report identified persistent bilateral wrist pain. She continued to have knee pain. Exam revealed right knee with well-healed arthroscopic portals. There was no swelling. The calf was not tender. Range of motion was limited.

IMR ISSUES, DECISIONS AND RATIONALES

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

KNEE SLEEVE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 1021-1022.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346-347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg ChapterODG states that prefabricated knee braces may be appropriate in patients with one of the following conditions: Knee instability; Ligament insufficiency/deficiency; Reconstructed ligament; Articular defect repair; Avascular necrosis; Meniscal cartilage repair; Painful failed total knee arthroplasty; Painful high tibial osteotomy; Painful unicompartmental osteoarthritis; Tibial plateau fracture. (ODG, Knee and Leg Chapter).

Decision rationale: The ACOEM Guidelines states that a brace can be used for patellar instability, ACL ligament tear, or medial collateral ligament instability. Usually a brace is necessary only if the patient is going to be stressing the knee under load such as climbing ladders or carrying boxes. The medical record do not clearly document any of the conditions for which a knee brace would be necessary. The medical necessity was not established. As such, the request is not medically necessary and appropriate.

VOLTAREN CREAM 100GM AS PRESCRIBED: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 112Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The most common adverse reactions were dermatitis and pruritus. (Voltaren package insert) Page(s): 112.

Decision rationale: The MTUS Chronic Pain Guidelines states that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); and has not been evaluated for treatment of the spine, hip or shoulder. While the patient has chronic knee pain, the medical records failed to reveal clear documentation of osteoarthritis. Medical necessity has not been established. As such, the request is not medically necessary and appropriate.