MAXIMUS Federal Services

Case Number:	CM14-0013058		
Date Assigned:	02/24/2014	Date of Injury:	05/21/2012
Decision Date:	08/15/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	01/31/2014

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 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 56-year-old female with a 5/21/12 date of injury. On 1/15/14 there were complaints of persistent left knee pain with grinding. Clinically there was medial joint line tenderness and positive McMurray sign. X-rays revealed no progressive degenerative changes. Diagnoses include residual meniscus tear of the left knee. Treatment plan discussed a left knee MR arthrogram to determine if the patient does in fact have a persistent meniscus tear. MRI dated 8/21/12 revealed tearing, delineation, subluxation/extrusion, and fraying of the medial meniscus, cartilage loss with subchondral bone cyst and subchondral marrow edema, mild chronic sprain of the medial collateral ligament, mild chronic sprain of the anterior and posterior cruciate ligament, osteophytes, and popliteal cyst. She underwent a left knee partial medial meniscectomy on 12/4/12, however continues to describe significant pain in 2013. 9/11/13 x-rays of the left knee showed progressive degenerative arthritis. Supartz injection was suggested.

IMR ISSUES, DECISIONS AND RATIONALES

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

MR ARTHROGRAM OF 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): 346-347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Official Disability Guidelines-Treatment in Worker's Compensation, Online EditionChapter: Knee and Leg (updated 05/09/12)MR arthrography.

Decision rationale: Medical necessity for the requested MR arthrogram is not established. MR arthrogram previously obtained an adverse determination as the patient underwent surgical intervention in 2012 and pain substantially decreased since 1/2013. Physical findings did not include significant loss of function, sensation, or motor strength, indicating necessity for additional imaging. Within the context of this appeal no additional medical records were provided describing positive provocative maneuvers, and any additional functional limitations in the knee. There were Visco supplementation treatment recommendations for degenerative arthritis in the knee. However, it is unclear if this was performed and if the patient obtained any significant pain relief. Without further clarification, the request is not medically necessary.

FLURBITAC (FLURBIPROFEN 100/100 MG # 60 WITH H2 BLOCKER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 47. Decision based on Non-MTUS Citation http://www.drugs.com/monograph/flurbiprofen.html.

Decision rationale: Medical necessity for the requested for Flurbitac is not established. This medication is a combination of flurbiprofen (NSAID) and ranitidine (H2 blocker). This request previously obtained an adverse determination due to potential side effects from chronic non-steroidal anti-inflammatory drug (NSAID)/Proton pump inhibitor (PPI) use. There is no documentation regarding frequency, duration or gastric side effects from the use of an NSAID. Furthermore, there is no discussion as to why a combination drug is necessary. Therefore, this request is not medical necessary.

KERATEK GEL 4OZ BOTTLE (HYDROCODONE): 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 Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004) See also Topical analgesics; & Topical analgesics, compounded Page(s): 105. Decision based on Non-MTUS Citation Keratek gelKERATEK (menthol, methyl salicylate) gel ¨[GERITREX CORP]DRUG FACTS: Active Ingredients PurposeMenthol 16% Topical analgesicMethyl Salicylate 28% Topical analgesichttp://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=5527b965-615b-4eff-8597-8c3e2e626f61.

Decision rationale: The request for Keratek gel is not medically necessary. The Claims Administrator stated that there was no reference regarding this topical medication yet an online

search revealed that the medication is a topical salicylate. MTUS guidelines supports the use of topical salicylates for pain management however, this request also contains hydrocodone. It is unclear if this is in combination with the topical salicylate. The provided medical records did not discuss this medication with indications of prior use, pain reduction or improved functionality. Without further clarification this request is not substantiated.

VICOSELTRON 10/300/2 MG #40 NARCOTIC ANALGESIC: 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) 79 – 80 and on the Non-MTUS Opioid Therapy for Chronic Pain, Opioid Treatment Guidelines from the American Pain Society and the American Academy of Pain Medicine, in addition to various review articles (see [redacted] and [redacted] review article from the New England Journal of Medicine).

Decision rationale: Medical necessity for Vicoseltron is not established. This medication is a narcotic analgesic however; it is unclear of the components (e.g., ingredients, indications, safety and efficacy). The CA MTUS Guidelines, Official Disability Guidelines (ODG) and online searches did not reference this medication. Therefore, due to the lack of information, this medication is not medically necessary.