

Case Number:	CM14-0139394		
Date Assigned:	09/05/2014	Date of Injury:	07/28/2013
Decision Date:	10/09/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	08/28/2014

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 Physical Medicine and Rehabilitation 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 injured worker is a 61 year old male with a reported date of injury on 07/28/2013. The mechanism of injury was exiting a vehicle. The injured worker's diagnoses included a right medial meniscus tear. The injured worker's previous treatments included rest, ice, and anti-inflammatories. The injured worker's previous diagnostic testing included right knee x-rays which showed normal bony anatomy and a right knee MRI which revealed an oblique complex tear of the posterior horn of the medial meniscus, evidence of subchondral fracture of the medial tibial plateau, evidence of precious lateral tibial plateau injury and a mild sprain of the proximal tibial collateral ligament. No pertinent surgical history was provided. On 09/04/2013 a right knee focused examination revealed a normal gait and no swelling, ecchymosis, observable spasm, or obvious malalignment of the knee. Range of motion was measured as 180/180 degrees of flexion and 135/135 degrees of extension. There was no evidence of quadriceps atrophy. Motor strength of quadriceps and hamstring strength were measured at 5/5. Distal sensation was normal and patellar and Achilles reflexes were 2+. The McMurray sign was positive and he had medial joint line tenderness. The injured worker was evaluated on 10/22/2013 for right medial joint line pain. The clinician reported that the right knee McMurray test was positive. The plan was for arthroscopy. No specific medications were documented; however, anti-inflammatories were recommended. The requests were for 8 sessions of physical therapy and one prescription of Diclofenac/Lidocaine cream 3/5%, 180gm. No rationale for the requests were provided for review. The request for authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 sessions of physical therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine/Physical Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Medicine Guidelines

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

Decision rationale: The request for 8 sessions of physical therapy is not medically necessary. The injured worker complained of right knee pain. The California MTUS Guidelines note active physical therapy based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines recommend 9-10 sessions of physical therapy over 8 weeks. The physical exam revealed normal range of motion and strength to the right knee. The injured worker complained of pain with certain activities but the pain was controlled by anti-inflammatories and other specified conservative measures. There is a lack of documentation indicating the injured worker has significant objective functional deficits. There is a lack of documentation indicating whether the injured worker has had prior physical therapy, as well as the efficacy of any prior physical therapy. The submitted request does not indicate the site at which the physical therapy is to be performed. Therefore, the request for 8 sessions of physical therapy is not medically necessary.

One prescription of diclofenac/lidocaine cream 3/5%, 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-112.

Decision rationale: The request for one prescription of Diclofenac/Lidocaine cream 3/5%, 180gm is not medically necessary. The injured worker complained of ongoing right knee pain. The California MTUS Chronic Pain Medical Treatment Guidelines recommend Voltaren Gel 1% (Diclofenac) for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). The guidelines note Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain; no other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines do not recommend the use of topical lidocaine in cream form. As the guidelines note any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended, the medication would not be indicated. The

documentation provided did not indicate a diagnosis of osteoarthritis or neuropathic pain to a joint amenable to topical treatment. Additionally, the request did not include the site of administration, frequency for administration, or dosage amount. Therefore, the request for one prescription of Diclofenac/Lidocaine cream 3/5%, 180gm is not medically necessary.