

<b>Case Number:</b>	CM14-0178947		
<b>Date Assigned:</b>	11/03/2014	<b>Date of Injury:</b>	05/09/1995
<b>Decision Date:</b>	12/08/2014	<b>UR Denial Date:</b>	09/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/28/2014

### 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 Internal 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 injured worker (IW) is a 64-year-old man with a date of injury of May 9, 1995. The mechanism of injury was not documented in the medical record. According to the clinical notes, the IW had recent neck surgery with anterior cervical discectomy and fusion at C6-C7 performed on June 5, 2014. It is also notes that there were prior bilateral total knee replacements. Pursuant to the progress note dated September 11, 2014, The IW complains of neck, right shoulder, bilateral upper extremities, bilateral knees and pain in the bilateral feet. He is currently undergoing therapy for the cervical spine and has completed one of the six sessions. The provider states that it is too soon to evaluate his response. Pain is better with rest and medication, and worse with activity. Physical examination reveals decreased range of motion (ROM) in the cervical spine over the paraspinal muscles bilaterally. Kemp's test is positive bilaterally. Deep tendon reflexes 1++ bilaterally at patellar and Achilles tendons. There are well-healed surgical scars bilaterally over the anterior aspect of the knees. There is tenderness over the medial and lateral joint lines bilaterally. Varus and valgus stress test were positive bilaterally. Examination of the bilateral ankles and feet reveals slight decreased range of motion. There is tenderness over the lateral and medial malleoli on the left. The IW has been diagnosed with Cervical disc disease, status post cervical fusion; lumbar disc disease; bilateral total knee replacement with chronic pain; left shoulder pain status-post dislocation on June 12, 2014; right shoulder sprain/strain; and bilateral ankle sprain/strain. The physical is recommending physical therapy for the bilateral feet at two times a week for 3 weeks, He is also requesting knee braces, which he received in the past but did not fit correctly. Kera-Tek gel is being prescribed for chronic pain. The IW is instructed to continue follow-up with pain management, as well as the internist. He has an upcoming appointment for a CT scan of the left shoulder. He is to follow-up in 4 weeks for re-evaluation.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy (bilateral feet) 2 times per week for 3 weeks:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Extremity Section, Physical Therapy

**Decision rationale:** Pursuant to the Official Disability Guidelines, physical therapy two times per week for three weeks to the feet bilaterally is not medically necessary. Physical medicine guidelines allow for fading treatment frequency (from up to three visits per week to one or less) plus active self-directed home PT. One remaining option; effusion of joint 9 visits over 8 weeks. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process to maintain improvement levels. In this case, there is no documentation to support injuries to the feet and/or any prior physical therapy to the feet until a September 11, 2014 progress note. It is unclear whether the guideline PT (frequency and duration) has been exceeded. Presently, there is nothing in the medical record to support additional physical therapy based on clinical facts in the medical record. The injured worker's diagnosis today or cervical disc disease, status post cervical fusion, lumbar disc disease, and bilateral total in the replacement with chronic pain. There is no specific diagnosis referencing the feet. In a progress note dated September 11, 2014 physical examination showed tenderness to the plantar fascia. Based on the clinical information in the medical record in the peer-reviewed evidence-based guidelines, physical 2 times per week for three weeks to the feet bilaterally is not medically necessary.

**Kera-Tek Gel, 4oz.:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain section, Topical analgesics

**Decision rationale:** Pursuant to the official disability guidelines, Keratek Gel is not medically necessary. Keratek contains menthol and methyl salicylate. Topical analgesics are largely experimental with few controlled trials to determine efficacy and safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Menthol is not recommended. In this case, the treating physician requested Keratek gel. Menthol is not recommended. Any compounded product that contains at least one drug (menthol) is not recommended, is not recommended. Consequently,

Keratek the gel is not recommended. Based on the clinical information in the medical record in the peer-reviewed evidence-based guidelines, Keratek gel is not medically necessary.

**Custom Fitted/Molded Bilateral Knee Braces:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lower Extremity Section, Knee Braces

**Decision rationale:** Pursuant to the ACOEM practice guidelines and the Official Disability Guidelines, custom fitted/molded bilateral knee braces are not medically necessary. The guidelines state a brace can be used for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability although its benefits may be more emotional than medical. 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. For the average patient, using the brace is usually unnecessary. In this case, there is no indication in the documentation that bracing the knees bilaterally would be appropriate and medically necessary. The injured worker had two total knee replacements. The injured worker ambulates without difficulty, however. Range of motion in and about the knees bilaterally is decreased. Based on clinical information in the medical record of the peer-reviewed there is no indication in the injured worker will be stressing the knee under load record and consequently, the knee braces bilaterally are not medically necessary.