

<b>Case Number:</b>	CM14-0035467		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	09/06/2013
<b>Decision Date:</b>	08/12/2014	<b>UR Denial Date:</b>	03/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/21/2014

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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 48-year-old female who reported an injury on 09/06/2013 after carrying boxes. The injured worker reportedly sustained an injury to her low back and right knee. The injured worker underwent an MRI on 12/17/2013. It was documented that there was evidence of a meniscal tear of the right knee and a partial tear of the posterior collateral ligament with mild tendonitis of the quadriceps ligament. The injured worker's treatment history included medications and physical therapy. The injured worker was evaluated on 01/29/2014. It was noted that that the injured worker had continued right leg pain rated at an 8/10. Physical findings included joint line tenderness of the knee with decreased range of motion. The injured worker diagnoses included lumbosacral disc protrusion, right knee internal derangement, and left shoulder sprain/strain. The injured worker was evaluated on 02/14/2014. It was documented that the injured worker had peripatellar tenderness of the right knee. A request was made for acupuncture, chiropractic care, pain management, a urinary analysis, surgical intervention for the right knee and topical compounds.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient right knee arthroscopic meniscectomy and outpatient transportation services:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Transportation (to & from appointments).

**Decision rationale:** The requested outpatient right knee arthroscopic meniscectomy and outpatient transportation services are not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend surgical intervention for knee injuries for patients who have significant functional deficits consistent with pathology identified on an imaging study. The clinical documentation does indicate that the injured worker has a torn meniscus and evidence of a torn PCL; however, the clinical documentation submitted for review does not provide significant mechanical symptoms to support a diagnosis of meniscus derangement. There is no documentation of a positive McMurray's sign, or evidence of restricted range of motion due to locking, popping or instability. Therefore, a meniscectomy would not be indicated in this clinical situation. Additionally, Official Disability Guidelines only support transportation for patients who have documented findings limiting their ability to drive to medical appointments. The clinical documentation submitted for review does not clearly identify that the patient cannot adequately provide self-transportation. Therefore, the need for outpatient transportation services would not be indicated. As such, the requested outpatient right knee arthroscopic meniscectomy and outpatient transportation services is not medically necessary or appropriate.

**Outpatient urinalysis for toxicology:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pain management referral:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** The requested pain management referral is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend pain management referral for patients who have exhausted all lower levels of treatment and require additional expertise for treatment planning. The clinical documentation submitted for review does not provide evidence that patient has exhausted all lower levels of treatment and

would benefit from the additional expertise of a pain management specialist. As such, the requested pain management referral is not medically necessary or appropriate.

**Flurbiprofen/capsaicin/menthol 10/0.25/2/1 % 120 GM: 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.

**Decision rationale:** The requested flurbiprofen/capsaicin/menthol 10/0.25/2/1% 120 grams is not medically necessary or appropriate. Chronic Pain Medical Treatment Guidelines does not recommend the use of nonsteroidal anti-inflammatory drugs as topical agents unless there is documentation that oral formulations of this medication are contraindicated to the patient. The clinical documentation submitted for review does not provide any reason that the patient is unable to tolerate nonsteroidal anti-inflammatory drugs in an oral formulation. Additionally, California Medical Treatment Utilization Schedule does not support the use of capsaicin as a topical agent unless there is a failure to respond to all first line treatments. The clinical documentation submitted for review does not provide any evidence that the injured worker has failed to respond to first line medications to include antidepressants and anticonvulsants. Therefore, the use of this medication would not be indicated. As such, the requested flurbiprofen/capsaicin/menthol 10/0.25/2/1% 120 grams is not medically necessary or appropriate.

**Ketoprofen/cyclobenzaprine/lidocaine 10%/3%/5% 120GM: 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.

**Decision rationale:** The requested ketoprofen/cyclobenzaprine/lidocaine 10%/3%/5% 120 grams is not medically necessary or appropriate. Chronic Pain Medical Treatment Guidelines does not support the use of ketoprofen or lidocaine in a topical formulation as they are not FDA approved to treat neuropathic pain. Additionally, Chronic Pain Medical Treatment Guidelines does not support the use of muscle relaxants as topical analgesics as there is little scientific evidence to support the efficacy and safety of these medications. As such, the requested Ketoprofen/Cyclobenzaprine/Lidocaine 10%/3%/5% 120 grams is not medically necessary or appropriate.

**Follow up in (4) weeks: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Office Visits.

**Decision rationale:** The requested followup in 4 weeks is not medically necessary and appropriate. Chronic Pain Medical Treatment Guidelines does not directly address evaluation management of knee injuries. Official Disability Guidelines recommend ongoing evaluation and management of a knee injury to evaluate the need for further treatment and symptom response to treatment. The clinical documentation submitted for review does indicate that the injured worker has chronic pain that does require followup management; however, the request as it is submitted does not specifically identify with whom the followup evaluation is being requested or justification for the need for this followup. As such, the requested followup in 4 weeks is not medically necessary or appropriate.