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| Case Number: | CM14-0047664 | | |
| Date Assigned: | 06/25/2014 | Date of Injury: | 11/15/2011 |
| Decision Date: | 08/13/2014 | UR Denial Date: | 03/03/2014 |
| Priority: | Standard | Application Received: | 03/31/2014 |

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 injured worker is a 56-year-old male who sustained an injury on 11/15/11. No specific mechanism of injury was noted. This appears to have been a cumulative trauma type injury. The injured worker was initially started on physical therapy and was eventually referred to an orthopedist. The injured worker did undergo a right knee arthroscopic meniscectomy on 05/08/12 followed by postoperative physical therapy. Medications did include topical analgesics. The injured worker was also referred for chiropractic therapy. It is also noted that the injured worker was treated for concurrent psychological symptoms to include depression and anxiety. The clinical report from 01/30/14 noted that the injured worker had continuing complaints of pain moderate to severe in the bilateral knees, right side worse than left. The injured worker continued to demonstrate positive McMurray's signs to the right with tenderness to palpation and loss of range of motion. The injured worker was continued with a home exercise program and prescribed continuing topical analgesics. There was a recommendation for a revision right knee arthroscopy. There was a qualified medical evaluator report from 02/17/14 which reviewed a magnetic resonance image study that was not available for review. The report indicated that there did appear to be a possible recurrent tear in the medial meniscus. The injured worker was felt to have symptoms consistent with a symptomatic meniscal tear per the report. There were recommendations for further consideration regarding surgical intervention. Follow up on 04/17/14 noted that the injured worker continued to have positive McMurray's signs in the right knee with loss of range of motion and tenderness to palpation. The injured worker was utilizing anti-inflammatories including Motrin as well as muscle relaxers at this evaluation. The injured worker was also continuing to utilize topical analgesics. The injured worker was again recommended for revision right knee arthroscopy. The requested right knee arthroscopic surgery

with a home exercise program as well as Fluoroflex 180 grams and TG Hot 180 grams were all denied by utilization review on 03/03/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee arthroscopic surgery: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Official Disability Duration Guidelines, Treatment in Workers Compensation, Web-based edition. web-based edition, http://www.dir.ca.gov/t8/ch4_5sbia5__2.html.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 345-347.

Decision rationale: In regards to the request for a right knee arthroscopy, this reviewer would not have recommended this request as medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. While the injured worker does have continuing physical examination findings consistent with a possible recurrent meniscal tear, no imaging studies of the right knee were available for review identifying evidence of a recurrent meniscectomy that would support surgical intervention. Furthermore, guidelines do indicate that revision meniscectomy procedures have a very low likelihood of providing any further functional improvement or pain relief. Given the absence of any imaging studies confirming a symptomatic meniscal tear of the right knee, this reviewer would not have recommended this request as medically necessary.

Home Exercise Program: Overturned

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 & Leg Chapter, Exercise.

Decision rationale: In regards to the home exercise program for this injured worker, this reviewer would have recommended this request as medically necessary. A home exercise program can be easily performed by the injured worker and does not require any supervisory experience from a physical therapist or medical physician. Therefore, this request is medically necessary.

Fluriflex 180gm: 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 Analgesics Page(s): 111-113.

Decision rationale: In regards to the use of Fluriflex 180gm, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The Chronic Pain Treatment Guidelines and United States Food and Drug Administration note that the efficacy of compounded medications has not been established through rigorous clinical trials. The Food and Drug Administration requires that all components of compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen which is not approved for transdermal use. The clinical documentation provided did not discuss the claimant's prior medication use and did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.

TGHOT 180GM: 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 Analgesics Page(s): 111-113.

Decision rationale: In regards to the use of TGHOT 180gm, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The Chronic Pain Treatment Guidelines and United States Food and Drug Administration note that the efficacy of compounded medications has not been established through rigorous clinical trials. The Food and Drug Administration requires that all components of compounded topical medication be approved for transdermal use. This compound contains Tramadol, Gabapentin, Menthol, Camphor and Capsaicin which are not approved for transdermal use. The clinical documentation provided did not discuss the claimant's prior medication use and did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.