

Case Number:	CM14-0086608		
Date Assigned:	07/23/2014	Date of Injury:	08/21/2013
Decision Date:	08/29/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	06/09/2014

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, has a subspecialty in Interventional Spine 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 39-years-old female with an injury date on 08/21/2013. Based on the 04/14/2014 progress report provided by [REDACTED], the diagnoses are: 1. Right knee meniscal tear, status post arthroscopy. 2. Compensatory left lower extremity overuse syndrome. 3. Compensatory left foot strain. According to this report, the patient complains of right knee pain. Range of motion of the bilateral knee is decreased. McMurray's was positive bilaterally. Muscle strength was 4/5 in flexion and extension in the right knee and 5/5 in the left knee. The patient is status post right partial medial and lateral meniscectomy and chondroplasty on 01/06/2014. There were no other significant findings noted on this report. [REDACTED] is requesting: 1. Magnetic resonance arthrogram right knee 2. Physical therapy 2 times a week for 6 weeks 3. Flurbiprofen/Ranitidine 100/100mg #604. Thera Flex The utilization review denied the request on 05/09/2014. [REDACTED], is the requesting provider, and he provided treatment reports from 12/12/2013 to 05/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic Resonance Arthrogram Right Knee: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Per ODG Guidelines state Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Ramappa, 2007) Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended (Weissman, 2011). The patient recently had knee surgery from Jan 2014 and continues to be symptomatic. The physician's request for an updated MRI to evaluate post-op knee appears reasonable. Therefore,. Magnetic Resonance Arthrogram Right Knee is medically necessary.

Physical Therapy two (2) times a week for six (6) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: The patient is status post right partial medial and lateral meniscectomy and chondroplasty on 01/06/2014. This patient is outside of post-surgical time-frame and for therapy treatments. The utilization review denial letter modified the request to 6 sessions. For physical medicine, the MTUS guidelines recommend for myalgia and myositis type symptoms 9-10 visits over 8 weeks. Review of available records show the patient has had 18 post-operative physical therapy sessions. There does not appear to be any specific reason(s) provided by the treater as to why this patient would require more therapy than what is allowed by MTUS. The treater is requesting an addition 12 sessions; however, there is no current functional status described to consider additional therapy. Additional therapy can be considered with functional improvement but in this case, the physician requests additional therapy without discussing how the patient is doing. In addition, the requested for Physical Therapy two (2) times a week for six (6) weeks is not medically necessary.

Flurbiprofen/Ramitidine 100/100 mg. #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG):Compounded Medication.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The MTUS guidelines recommends for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. In this case, the patient does not meet the indication for the topical medication as she does not present with any osteoarthritis or tendonitis symptoms. In addition, Lidocaine is only allowed in a patch form and not allowed in cream, lotion or gel forms. The MTUS Guidelines page 111 has the following regarding topical creams, topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety. MTUS further states, Any

compounded product that contains at least one (or drug class) that is not recommended is not recommended. Therefore,. Flurbiprofen/Ramitidine 100/100 mg. #60 is not medically necessary.

Thera Flex: 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: Regarding topical lidocaine, MTUS guidelines states, 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 (Antiepileptic drugs) such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA (Food and Drug Administration) for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. MTUS further states, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. For salicylate, a topical NSAID, MTUS does allow it for peripheral joint arthritis/tendinitis problems. The patient does present with peripheral joint problems to warrant a compound product with salicylate. However, the MTUS guidelines do not allow any formulation of Lidocaine other than in patch form. Therefore, Thera Flex is not medically necessary.