

<b>Case Number:</b>	CM14-0204268		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	11/23/2011
<b>Decision Date:</b>	02/10/2015	<b>UR Denial Date:</b>	11/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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 Family Practice 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:

This is a 29 year old male patient who sustained a work related injury on 11/23/13. The exact mechanism of injury was not specified in the records provided. The current diagnoses include internal derangement of the knee on the right and s/p right knee meniscectomy; Discogenic lumbar condition with radicular component down the lower extremities. Per the doctor's note dated 11/12/14, patient has complaints of left knee pain and he was walking with a cane. Physical examination of the left knee revealed pain along the left knee medial greater than lateral joint line, negative patellar tilt test, tenderness along the inner and outer patella, 1+ anterior drawer test, negative Lachman test, negative valgus and varus testing, Positive McMurray's medially and negative laterally. The current medication lists include Omeprazole 40 mg, Gaviscon liquid and Bicarbonate. The previous medication list include Naproxen, Ketoprofen, Trazodone, Tramadol, Nalfon, Zofran, Effexor and various other medications including strong analgesics. The patient has had MRI on 07/22/13 that revealed tear of the posterior horn of medial meniscus and extending through the hosi and to the articular surface, internal derangement of the knee; EMGs in June 2013; MRI of the low back that revealed disc disease from L2 through S1; MRI of the left knee on December 13, 2013 that revealed linear signal on the posterior horn of the medial meniscus consistent with tear. The patient's surgical history include right knee partial meniscectomy. The patient underwent stomach surgery on 2005. The patient has received 24 sessions of physical therapy with chiropractic treatment for this injury. The patient has used transcutaneous electrical nerve stimulation (TENS) unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Knee Orthosis, Adjustable: 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): 340.

**Decision rationale:** Per the ACOEM guidelines cited below "A brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability although its benefits may be more emotional (i.e., increasing the patient's confidence) than medical.... For the average patient, using a brace is usually unnecessary" In addition per the ODG Guidelines knee brace is recommended for, "1. Knee instability, 2. Ligament insufficiency/deficiency, 3. Reconstructed ligament, 4. Articular defect repair 5. Avascular necrosis, 6. Meniscal cartilage repair, 7. Painful failed total knee arthroplasty 8. Painful high tibial osteotomy, 9. Painful unicompartmental osteoarthritis, and 10. Tibial plateau fracture." Any evidence of recent surgery of the left knee was not specified in the records provided. The presence of any of these indications in this patient was not specified in the records provided. Any evidence of the need for stressing the knee under load such as climbing ladders or carrying boxes was not specified in the records provided. The patient has received 24 sessions of physical therapy with chiropractic treatment for this injury. Detailed response to this conservative therapy was not specified in the records provided. Prior conservative therapy notes were not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Left Knee Orthosis, Adjustable is not fully established for this patient.

**Crutches for the left knee: 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): 340. Decision based on Non-MTUS Citation Other Guidelines Official Disability Guidelines (ODG) Knee & Leg (updated 01/30/15) Walking aids (canes, crutches, braces, orthoses, & walkers).

**Decision rationale:** Any evidence of recent surgery of the left knee was not specified in the records provided. The presence of any of these indications in this patient was not specified in the records provided. Any evidence of the need for stressing the knee under load such as climbing ladders or carrying boxes was not specified in the records provided. The patient has received 24 sessions of physical therapy with chiropractic treatment for this injury. Detailed response to this conservative therapy was not specified in the records provided. Prior conservative therapy notes were not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Crutches for the left knee is not fully established for this patient.

## **Polar Care for 21 Day Rental for the Left Knee: 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 & Leg (updated 01/30/15) Continuous-flow cryotherapy.

**Decision rationale:** ACOEM and CA MTUS do not address this request. Therefore ODG used. Per the cited guidelines Continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment....The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting... There is limited information to support active vs passive cryo units.. cryotherapy after TKA yields no apparent lasting benefits, and the current evidence does not support the routine use of cryotherapy after TKA" Any recent surgery or procedures related to this injury were not specified in the records provided. Any operative note was not specified in the records provided. The patient has received 24 sessions of physical therapy with chiropractic treatment for this injury. The response of the symptoms to a period of rest, oral pharmacotherapy and splint is not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Polar Care for 21 Day Rental for the Left Knee is not fully established in this patient.

## **Zofran 8mg #20: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2014, Pain, Antiemetics (for opioid nausea)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (updated 11/21/14) Antiemetics (for opioid nausea) Thompson micromedex Ondansetron FDA labeled indication.

**Decision rationale:** Ondansetron is 5-HT<sub>3</sub> receptor antagonist which acts as anti-emetic drug. CA MTUS/ACOEM do not address this request. Therefore ODG and Thompson Micromedex was used. Per ODG, "Antiemetics (for opioid nausea), Not recommended for nausea and vomiting secondary to chronic opioid use" According to the Thompson micromedex guidelines, FDA labeled indications for Ondansetron include, "Chemotherapy-induced nausea and vomiting, highly emetogenic chemotherapy; Prophylaxis; Chemotherapy-induced nausea and vomiting, moderately emetogenic chemotherapy; Prophylaxis; Postoperative nausea and vomiting; Prophylaxis and Radiation-induced nausea and vomiting; Prophylaxis." Any indication listed above was not specified in the records provided. A rationale for use of this medication was not

specified in the records provided. Any abnormal findings on GI examination were not specified in the records provided. The clinical information submitted for this review does not establish the medical necessity of the Zofran 8mg #20 for this patient at this juncture.

**Amoxicillin/Clavulanate 875/125 #20:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th Edition (web), 2014 Infectious Diseases, Amoxicillin-Clavulanate

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th Edition (web), 2014 Infectious Diseases, Amoxicillin-Clavulanate.

**Decision rationale:** As per cited guideline the medication Amoxicillin-Clavulanate (Augmentin) "Recommended as first-line treatment for bite wounds and other conditions." Any evidence of bite wounds and other infectious conditions was not specified in the records provided. Rationale for the use of Amoxicillin/Clavulanate 875/125 #20 was not specified in the records provided. The medical necessity of the request for Amoxicillin/Clavulanate 875/125 #20 is not fully established in this patient.

**Gabapentin 600mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gabarone, generic available) Page(s): 18-19.

**Decision rationale:** Fanatrex contains gabapentin in oral suspension form. Gabapentin is an anti-epileptic drug. According to the CA MTUS Chronic pain guidelines "Gabapentin (Neurontin) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." Per the cited guidelines, "CRPS: Recommended as a trial. (Serpell, 2002) Fibromyalgia: Recommended as a trial. (Arnold, 2007) Lumbar spinal stenosis: Recommended as a trial, with statistically significant improvement found in walking distance, pain with movement, and sensory deficit found in a pilot study" Per the records provided, evidence of diabetic neuropathic pain or post herpetic neuralgia was not specified in the records provided. Response to NSAIDs was not specified in the records provided. Any objective evidence of neuropathic pain was not specified in the records provided. The medical necessity of Gabapentin 600mg #90 is not fully established for this patient at this time.