

Case Number:	CM15-0199490		
Date Assigned:	10/14/2015	Date of Injury:	12/01/2014
Decision Date:	11/25/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Washington, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 31 year old female who sustained a work related injury on 12-1-14. A review of the medical records shows she is being treated for left hip and left knee pain. She is currently not working. Treatment has included 12 physical therapy sessions, medications, and rest. In the progress note, dated 7-17-15, the injured worker reported persistent pain in her left knee and the lateral thigh. She rated her pain level a 7/10. She also reported intermittent left hip pain which she rated 7/10. She stated the pain had "slightly improved as she can bear weight evenly now and is no longer limping after her physical therapy sessions". Current medications include Motrin and Kera-Tek. She was taking Tramadol but it was making her dizzy and provider discontinued it. On physical exam she had decreased range of motion in left knee, positive varus and valgus stress tests, tenderness over the left hamstring muscle, +4/5 muscle weakness on left hip flexion, abduction and extension, and slight decrease in range of motion in left hip. The Request for Authorization dated 9-18-15 requested MRIs of the left hip and left knee and for Kera-Tek gel. In the Utilization Review dated 9-24-15, the requested treatments of Kera-Tek gel, an MRI of the left knee and an MRI of the left hip were deemed not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kera-Tek gel 4 oz, Qty 1, 30 day supply: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Salicylate topicals, Topical Analgesics.

Decision rationale: Kera-Tek gel is a topically used, compounded product made up of two active substances, menthol and methyl salicylate. It works by temporarily relieving minor aches and pain of muscles and joints (e.g., from arthritis, backache, sprains). Methyl salicylate is a non-steroidal anti-inflammatory medication (NSAID). Menthol is a topical analgesic medication with local anesthetic and counterirritant qualities. It is important to note the MTUS states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The MTUS recommends use of methyl salicylate for some inflammatory conditions that cause chronic pain but does not recommend it used for radicular pain. It does not comment on the topical use of menthol. This patient has non-radicular musculoskeletal pain and a trial of this medication is a viable option. There are no contraindications for use of Kera-Tek gel. Medical necessity for use of this preparation has been established. The request is medically necessary.

MRI (magnetic resonance imaging), left knee: Overturned

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies, Summary. Decision based on Non-MTUS Citation 1) American College of Radiology (ACR) Appropriateness Imaging Criteria for Acute Trauma to the Knee, 2008, Last Reviewed 2013; 2) American College of Radiology (ACR) Appropriateness Imaging Criteria for Non-traumatic Knee Pain, 1995, Last Reviewed 2012.

Decision rationale: Magnetic resonance imaging (MRI) scans are medical imaging studies used in radiology to investigate the anatomy and physiology of the body in both healthy and diseased tissues. MRIs of the knee are indicated in acute injuries with associated red flags, that is, signs and symptoms suggesting neurovascular compromise. In chronic situations the indications rely more on a history of failure to improve with conservative therapies, the need for clarification of anatomy before surgery, or to identify potentially serious problems such as tumors or infection. This patient had an injury to her left knee 2 years ago. The pain continues despite conservative treatment. The provider requested the MRI to look for causes of internal knee derangement that may be causing the patient's continued pain. This follows the indications for this test as noted above. Medical necessity for this procedure has been established. The request is medically necessary.

MRI (magnetic resonance imaging), left hip: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip - MRI (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies, Physical Examination. Decision based on Non-MTUS Citation 1) American College of Radiology (ACR) Appropriateness Imaging Criteria for Acute Hip Pain, 2013; 2) American College of Radiology (ACR) Appropriateness Imaging Criteria for Chronic Hip Pain, 1998, Last Reviewed 2011.

Decision rationale: Magnetic resonance imaging (MRI) scans are medical imaging studies used in radiology to investigate the anatomy and physiology of the body in both healthy and diseased tissues. MRIs of the hip are considered as a second imaging study to be performed after a simple radiograph in both acute and chronic hip pain evaluations. In chronic situations, the indications rely more on a history of failure to improve with conservative therapies, the need for clarification of anatomy before surgery, or to identify potentially serious problems such as tumors or infection. This patient had an injury to her left knee 2 years ago. The pain has continued despite conservative treatment. The request is to look for causes of internal hip derangement that may be causing the patient's continued pain. However, there is no documentation of a simple radiograph being performed. This request does not follow the guidelines for this test as noted above. Medical necessity for this procedure has not been established. The request is not medically necessary.