

Case Number:	CM15-0206161		
Date Assigned:	10/23/2015	Date of Injury:	09/05/2014
Decision Date:	12/04/2015	UR Denial Date:	09/26/2015
Priority:	Standard	Application Received:	10/20/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 49-year-old female who sustained an industrial injury on 9/5/14. Injury occurred when her left foot was caught on a wire near a water trench. The injured worker underwent arthroscopic left ankle extensive synovectomy and chondroplasty on 1/22/15. The 11/1/14 left knee MRI impression documented intrasubstance degeneration of the medial meniscus, without evidence of a tear. There was a single image demonstrating altered T2 signal along the free edge/inferior meniscal surface of the body of the lateral meniscus, a tiny tear was no excluded. There was a focus of high-grade cartilage loss measuring 2-3 mm along the posterior aspect of the medial femoral condyle. There was no subjacent marrow edema which could be degenerative versus posttraumatic. There was mild degenerative changes at the patellofemoral compartment. There was a small amount of edema seen within the suprapatellar fat pad, which could be associated with altered patellar tracking. The 8/11/15 treating physician report cited severe left knee pain radiating into the left lower calf. Pain was aggravated by physical activities such as standing, walking on uneven terrain, lifting, climbing stairs, kneeling, squatting, pivoting, and weight bearing. Physical exam documented antalgic stiff gait, inability to hop or squat, and left knee synovitis. There was tenderness over the medial and lateral joint lines, patella, and popliteal regions. Patellar compression test was positive. Range of motion was documented as 5 to 90 degrees with pain. There were positive spring and McMurrays tests, and 4/5 quadriceps, hamstring, and gastrocnemius weakness. X-rays of the left knee showed normal cartilage spaces, normal patellar height and tilt, and no loose bodies, arthritis or evidence of fracture. The diagnosis was left knee medial meniscus tear, left ankle anterior talofibular chronic

instability, anxiety, and insomnia. A MRI of the left knee was requested to confirm the diagnostic impression. The injured worker will need a left ankle anterior talofibular ligament reconstruction, followed by a left knee diagnostic arthroscopic with intraarticular surgery. Authorization was requested for Tramadol 150 mg #60, left ankle ligament reconstruction of the anterior talofibular ligament possibly using the peroneus brevis, left knee diagnostic arthroscopy with intraarticular surgery, Prilosec 20 mg 90, Xanax 1 mg #60, and gabapentin 300 mg #60. The 9/16/15 utilization review certified the requests for Tramadol 150 mg #60, left ankle ligament reconstruction of the anterior talofibular ligament possibly using the peroneus brevis, and Prilosec 20 mg 90. The request for left knee diagnostic arthroscopy with intraarticular surgery was non-certified based on lack of recent exhaustive conservative treatment and the treating physician's request for additional imaging for confirmation of his impressions. The request for Xanax 1 mg #60 was modified to Xanax 1 mg #10 consistent with the treating physician's reported indication for post-operative use for sleep and noting guideline recommendations for short term use. The request for gabapentin 300 mg #60 was non-certified as there was no indication that the injured worker had neuropathic symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) left knee diagnostic arthroscopy with intra articular surgery: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Meniscectomy.

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients who have activity limitation for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. Guidelines support arthroscopic partial meniscectomy for cases in which there is clear evidence of a meniscus tear including symptoms other than simply pain (locking, popping, giving way, and/or recurrent effusion), clear objective findings, and consistent findings on imaging. The Official Disability Guidelines (ODG) criteria for meniscectomy include conservative care (exercise/physical therapy and medication or activity modification) plus at least two subjective clinical findings (joint pain, swelling, feeling or giving way, or locking, clicking or popping), plus at least two objective clinical findings (positive McMurrays, joint line tenderness, effusion, limited range of motion, crepitus, or locking, clicking, or popping), plus evidence of a meniscal tear on MRI. The ODG recommend diagnostic arthroscopy when clinical indications are met. Indications include medications or physical therapy, plus pain and functional limitations despite conservative treatment, and imaging is inconclusive. Guideline criteria have not been met. This injured worker presents with persistent severe left knee pain radiating into the left lower extremity. Clinical exam findings were suggestive of a meniscus tear but this is not fully correlated by available imaging. The treating physician has opined the need for left knee MR arthrogram to fully evaluate the injured worker. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the knee, including exercise or physical

therapy, and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Xanax 1 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: The California MTUS do not recommend benzodiazepines (like Xanax) for long-term use (longer than two weeks), because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. Records indicate that this medication was being prescribed for post-operative use for sleep. The 9/16/15 utilization review modified this request for Xanax 1 mg #60 to #10 consistent with short-term post-operative use. There is no compelling rationale to support the medical necessity of additional medication beyond that currently certified and generally recommended by guidelines. Therefore, this request is not medically necessary.

Gabapentin 300 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: The California MTUS states that gabapentin 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. Guidelines state that there is limited evidence to show that this medication is effective for post-operative pain. Guideline criteria have not been met. This injured worker presents with left knee and ankle pain. She is diagnosed with left ankle anterior talofibular chronic instability and left knee medial meniscus tear. There is no evidence for neuropathic pain. Current opioid medication is certified for post-operative pain management. There is no compelling rationale to support the additional of this medication for pain management. Therefore, this request is not medically necessary.