

Case Number:	CM15-0033844		
Date Assigned:	03/26/2015	Date of Injury:	12/03/2013
Decision Date:	05/12/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/23/2015

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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports 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 57-year-old male who reported an injury on 12/03/2013. The mechanism of injury reportedly occurred when his right foot slipped off a curb. He was diagnosed with right knee internal derangement with loss of articular surface less than 1 mm medially and laterally with MRI showing meniscal tears medially and laterally as well and status post 1 cortisone injection with persistent symptomatology Past treatments included cortisone injections and therapy for the right knee. Diagnostic studies included an MRI of the right knee, performed on 01/22/2014, which demonstrated degenerative changes, particularly of the medial compartment and also significant patellofemoral narrowing and moderate lateral compartment narrowing. He had medial and lateral meniscus tears, a small joint effusion, and prominence cyst of the ganglion formation poster medially or above. Other diagnostic studies included an x-ray of the injured worker's right knee, performed on 02/10/2015, with findings of joint fluid as well as 1 mm articular surface left. His surgical history was included a liver transplant, performed in 10/2007. The injured worker presented on 03/09/2015 with complaints of right knee pain. The injured worker rated his pain as constantly a 9/10. The injured worker used a cane at home for prolonged ambulation. The injured worker reported that his knee also buckled and his walking was limited to 2 to 3 minutes, which point the pain sets in. Upon physical examination, the injured worker was able to stand on toes and heels. Additionally, it was noted that he could squat less than a fourth of the way. Lumbar flexion was less than 30 degrees and extension was less than 10 degrees. Lying supine, Milgram's testing was negative. The injured worker had negative

straight leg raise tests bilaterally. Hip flexion was at 100 degrees on the right and 105 degrees on the left. Patrick's tests were negative bilaterally. The injured worker had mild crepitation with range of motion bilaterally. Abduction was at 30 degrees bilaterally, external rotation was at 30 degrees bilaterally, internal rotation was at 20 degrees bilaterally, and extension of the knees was at 180 degrees on the left and 160 degrees on the right. The injured worker had flexion to 145 degrees on the left knee with no discomfort. Flexion on the right was at 70 to 75 degrees. The injured worker was noted to have tenderness along the medial and lateral joint lines on the right knee. The injured worker had a negative anterior drawer test and a negative Lachman's test. The injured worker had negative valgus and varus testing. The injured worker had a positive McMurray's test medially and negative laterally. The injured worker had tenderness along the inner and outer patella and a positive patellar tilt test. The injured worker had an equivocal compression test and negative inhibition tests. Dorsiflexion was at 10 degrees and plantar flexion was at 50 degrees bilaterally. The injured worker was noted to be neurologically intact. Deep tendon reflexes were at 2+ and symmetric bilaterally. The injured worker had full strength and to restricted function. His current medication regimen included Norco, tramadol, and Nalfon. The treatment plan indicated that there had been a certification for the injured worker's knee surgery that was received on 01/27/2015. It was also indicated that the injured worker had been approved for a hinge brace and a prescription for Norco 325 mg (#60). Furthermore, it was noted that the injured worker had been approved for tramadol ER 150 mg (#30) and Nalfon 400 mg (#60). It was additionally noted that the injured worker had been authorized for only 20 tablets of Flexeril. The clinical note indicated that 60 tablets of Flexeril would be provided because the electronic mailing was sent on 01/14/2015 and the authorization was untimely. The clinical note further indicated that similarly, the TENS unit was denied untimely and would be provided to the injured worker. Furthermore, the treatment plan indicated that the hot and cold wrap would be provided since it was denied in an untimely manner. Protonix 20 mg #60 and Trazodone 50 mg #60 had been untimely and would therefore be provided as well as LidoPro cream. The treatment plan further indicated that all the supplies for the surgery that had been denied should have been provided. The treatment plan also indicated that blood testing for liver and kidney function would be done in preparation for the surgery. The clinical note and the treatment plan further indicated that the injured worker had blood pressure that injured worker needed to get under control before his surgery could be performed. The rationale for the request was that all supplies for the surgery that were denied should have been provided. A Request for Authorization form, dated 02/10/2015, was included in the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Chest X-Ray: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, TWC, Preoperative testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Preoperative testing, general.

Decision rationale: The request for a chest x-ray is medically necessary. The injured worker had right knee pain and had been previously authorized for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy under general anesthesia on 01/27/2015. The documentation submitted for review provided evidence that the injured worker had signs or symptoms of active cardiovascular disease. As the documentation submitted for review provided evidence that the injured worker has hypertension, and at his last clinical evaluation, his blood pressure was at 188/128, and that the surgery could not be performed until the injured worker's high blood pressure was under control. The request as submitted is certified. As such, the request for associated surgical service: chest x-ray is medically necessary.

Associated surgical service: EKG: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, TWC, Preoperative testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Preoperative testing, general.

Decision rationale: The request for an EKG is medically necessary. The injured worker has right knee pain and was previously authorized for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy under general anesthesia on 01/27/2015. The Official Disability Guidelines state that patients with signs and symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. The documentation submitted for review provided evidence that the injured worker has hypertension. Furthermore, the documentation submitted for review provided evidence that at the injured worker's last clinical evaluation the injured worker's blood pressure was at 188/128 and would not be performed until the injured worker's high blood pressure was under control. Given the above, the request for EKG is medically necessary.

Associated surgical service: Polar Care 21 Day Rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines, TWC, Knee and Leg Procedure Summary, Continuous-flow cryotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines, Knee, Continuous-flow cryotherapy.

Decision rationale: The request for Polar care 21 day rental is not medically necessary. The injured worker had right knee pain. Additionally, the documentation submitted for review provided evidence that the injured worker had been authorized for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy under general anesthesia on 01/27/2015. Furthermore, the documentation submitted for review provided evidence that as the injured

worker's surgery met medical necessity, the recommendation for a partial certification for a cold therapy unit for 7 days has been previously authorized. The Official Disability Guidelines recommend continuous flow cryotherapy) as an option after surgery, but not for nonsurgical treatment. Postoperative use may generally be up to 7 days, including home use. As the documentation submitted for review provided evidence that there has been a previous partial certification for a cold therapy unit for 7 days, the request as submitted is not medically necessary. As such, the request for Polar care 21 day rental is not medically necessary.

Associated surgical service: ELS Range of Motion Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines, TWC, Knee and Leg Procedure Summary, Criteria for use of Knee Braces.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): s 346-347.

Decision rationale: The request for an ELS range of motion brace is not medically necessary. The injured worker has right knee pain and was previously authorized for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy under general anesthesia on 01/27/2015. Additionally, the documentation submitted for review provided evidence that the injured worker was previously approved for a hinge knee brace. As such, the request for an ELS range of motion brace is not medically necessary.

Associated surgical service: TENS Unit with Conductive Garment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post-operative pain (transcutaneous electrical nerve stimulation) Page(s): s 116-117.

Decision rationale: In regard to the request for a TENS unit with conductive garment, the request is not medically necessary. The injured worker has right knee pain. Additionally, the injured worker has been authorized for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy, approved on 01/27/2015. The California MTUS Treatment Guidelines recommend postoperative use of a TENS unit for mild to moderate thoracotomy pain. The documentation submitted for review failed to provide evidence that the injured worker would be undergoing a surgical procedure for a thoracotomy. Additionally, the guidelines state that the TENS unit has been shown to be of lesser effect or not at all for other orthopedic surgical procedures. Given the above, the request for a TENS unit with conductive garment is not medically necessary.

Associated surgical service: Hot and Cold Wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines, TWC, Knee and Leg Procedure Summary, Continuous-Flow Cryotherapy, Heat.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337.

Decision rationale: In regard to the request for hot and cold wrap, the request is not medically necessary. The injured worker has right knee pain and has been previously authorized for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy, approved on 01/27/2015. The Official Disability Guidelines recommend continuous flow cryotherapy. Furthermore, the documentation submitted for review provided evidence that the injured worker had been previously approved for a 7 day rental of a continuous flow cryotherapy unit. As such, the request for a hot and cold wrap is not medically necessary.

Amoxicillin Clavulanate 875mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Sanford Guide to Antimicrobial Therapy 2013, 43rd Edition, Antibiotic Prophylaxis to prevent surgical infections in Adults, pages 192-196.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goyal, N., et al. "Methicillin-resistant Staphylococcus aureus (MRSA) Colonisation and pre-operative screening." Bone & Joint Journal 95.1 (2013): 4- 9.

Decision rationale: The request for amoxicillin clavulanate 875 mg #20 is not medically necessary. The injured worker right knee pain and has been previously authorized on 01/27/2015 for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy. An article titled "Methicillin-Resistant Staphylococcus Aureus Colonisation and Pre-Operative Screening" indicated that there was some controversy about the effectiveness of screening and eradication programs; however, the literature suggests that patients should be screened and MRSA positive patients treated before surgical admission in order to reduce the risk of surgical site infections. The documentation submitted for review failed to provide evidence that the injured worker was screened and tested positive for staphylococcus aureus. Given the above, the request for amoxicillin clavulanate 875 mg is not medically necessary.

Topamax 50mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): s 16-18.

Decision rationale: The request for Topamax 50 mg #120 is medically necessary. The injured worker has right knee pain and was authorized on 01/27/2015 for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy. The documentation submitted for review provided evidence that the injured worker had a diagnosis of osteoarthritis of the knee. The California MTUS Guidelines state that antiepileptic drugs may also be an option for postoperative pain, resulting in decreased opioid consumption. As such, the request for Topamax 50 mg #120 is medically necessary.

Protonix 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: Regarding the request for Protonix 20 mg #60, the request is not medically necessary. The injured worker has right knee pain and was approved for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy on 01/27/2015. The California MTUS Guidelines state that clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors. Additionally, the guidelines state that the clinician should determine if the patient is at risk for gastrointestinal events. The documentation submitted for review failed to provide evidence that the injured worker was greater than 65 years of age; has a history of peptic ulcer, GI bleed, or perforation; concurrent use of aspirin, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID use. In the absence of the aforementioned documentation, the request for Protonix 20 mg #60 is not medically necessary.

Flexeril 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines, TWC Pain Procedure Summary, Non-sedating muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): s 63-66.

Decision rationale: The request for Flexeril 7.5 mg #60 the request is not medically necessary. The injured worker has right knee pain and was authorized on 01/27/2015 for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy. The California MTUS Guidelines recommend non-sedating muscle relaxants as a second line option for short term treatment of acute exacerbations of chronic LBP. The documentation submitted for review provided evidence that the injured worker had a previous modified approval for Flexeril 7.5 mg #20 on 01/27/2015. Given the above, the request for Flexeril 7.5 mg #60 is not medically necessary.

Trazodone 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): s 13-16.

Decision rationale: The request for Flexeril 7.5 mg #60 the request is not medically necessary. The injured worker has right knee pain and was authorized on 01/27/2015 for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy. The California MTUS Guidelines recommend non-sedating muscle relaxants as a second line option for short term treatment of acute exacerbations of chronic LBP. The documentation submitted for review provided evidence that the injured worker had a previous modified approval for Flexeril 7.5 mg #20 on 01/27/2015. Given the above, the request for Flexeril 7.5 mg #60 is not medically necessary.

LidoPro Lotion 4oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): s 111-112.

Decision rationale: The request for LidoPro lotion 4 ounces is not medically necessary. The injured worker has right knee pain was authorized on 01/27/2015 for a right knee arthroscopy with decompression, chondroplasty, and meniscectomy. The California MTUS Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Additionally, the guidelines state that they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation submitted for review failed to provide evidence that the injured worker had failed antidepressants or anticonvulsants. Given the above, the request as submitted is not medically necessary.