

Case Number:	CM15-0034109		
Date Assigned:	03/02/2015	Date of Injury:	09/02/2006
Decision Date:	04/15/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	02/24/2015

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: Physical Medicine & Rehabilitation

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 44-year-old female, who sustained an industrial injury on September 2, 2006. She has reported twisting her body while reaching, feeling a popping sensation in her left knee. The diagnoses have included knee pain. Treatment to date has included Synvisc injection, left knee arthroscopy in 2008 with revision in 2012, physical therapy, acupuncture, bracing, and medications. Currently, the injured worker complains of bilateral knee pain. The Treating Physician's report dated January 20, 2015, noted the injured worker with bilateral knee pain at the end of extension, with reported right knee misalignment with pain at times. The injured worker was noted to be interested in a Functional Restorative Program to improve her overall function and improve recovery time with pending surgery. On February 6, 2015, Utilization Review non-certified a Functional Restorative program evaluation, CT of the left knee, and Voltaren gel. The UR Physician noted the injured worker had not exhausted all treatment modalities, and since the injured worker was approved for orthopedic surgeon evaluation and since all treatment modalities had not been exhausted, the request for a Functional Restorative program evaluation was non-certified, citing the MYUS Chronic Pain Medical Treatment Guidelines and the MTUS American College of Occupational and Environmental Medicine (ACOEM) Guidelines. Since the referral to an orthopedic surgeon was certified the request for a CT of the left knee was non-certified, leaving the determination of the necessity of the CT to the orthopedic surgeon, citing the Official Disability Guidelines (ODG). The request for Voltaren gel was non-certified as topical analgesic preparations do not have any evidence based proven efficacy or safety, citing the MTUS Chronic Pain Medical Treatment Guidelines. On February

24, 2015, the injured worker submitted an application for IMR for review of a Functional Restorative program evaluation, CT of the left knee, and Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restorative Program Eval: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs (FRPs). Decision based on Non-MTUS Citation ACOEM Chapter 7, page 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 30-32.

Decision rationale: The 2/06/15 Utilization Review letter states the Functional Restoration Program Evaluation requested on the 1/20/15 report, was denied because the claimant has not exhausted all treatment modalities. According to the 1/20/15 medical report, the patient presents with bilateral knee pain and has been diagnosed with stable knee pain. The plan was for a CT scan of the left knee; Voltaren gel, Percocet; and an FRP. The patient showed interest in the FRP to improve her overall function and improve recovery time with pending surgery. MTUS Chronic Pain Medical Treatment Guidelines, pages 30-32, under Chronic pain programs (functional restoration programs), lists the Criteria for the general use of multidisciplinary pain management programs and states all criteria must be met. The criteria include: The patient has a significant loss of ability to function independently resulting from the chronic pain and the patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success above have been addressed. The available medical reports do not indicate that the patient has loss of ability to function independently, there is no discussion of the negative predictors of success, or whether the patient is willing to forgo secondary gains including disability payments. The reporting does not meet the MTUS criteria for a functional restoration program. The request for a Functional Restoration Program Evaluation IS NOT medically necessary.

CT of left knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Computed tomography (CT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official disability guidelines Knee chapter, for Knee Arthroscopy.

Decision rationale: The 2/06/15 Utilization Review letter states the CT of the left knee requested on the 1/20/15 report, was denied because the claimant has been authorized for an orthopedic consultation. According to the 1/20/15 medical report, the patient presents with

bilateral knee pain and has been diagnosed with stable knee pain. The plan was for a CT scan of the left knee; Voltaren gel, Percocet; and an FRP. The patient showed interest in the FRP to improve her overall function and improve recovery time with pending surgery. The exam shows the patient uses a left knee brace, there is pain at the end of extension, negative effusion or crepitus. The 11/20/14 report states the patient had 2 prior surgeries on the left knee, and that the CT scan is to evaluate further osteoarthritis as the patient may be a candidate for a total knee replacement. MTUS/ACOEM guidelines did not discuss knee replacement surgery. ODG guidelines, Knee chapter, for Knee Arthroscopy, indications for surgery state the patient should be over 50 years old. The records show this patient is 44 years old. The patient does not meet ODG requirements for a knee TKA, and therefore would not require the CT scan to evaluate the osteoarthritis for a total knee replacement. MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Knee Complaints Ch. 13, Special Studies and Diagnostic and Treatment Considerations, pg 341-343 states: Special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. ODG guidelines for Computerized tomography (CT) of the knee states "CT is not recommended for routine preoperative templating in TKA." The patient is not in the correct age group for a total knee replacement surgery, and ODG guidelines do not recommend routine CT scans for preoperative planning for a TKA. The request for CT of the left knee IS NOT medically necessary at this time.

Voltaren Gel: Overturned

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

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

Decision rationale: The 2/06/15 Utilization Review letter states the Voltaren gel requested on the 1/20/15 report, was denied because oral medications are effective and there is no documented failure of antidepressants or antiepileptic medications. According to the 1/20/15 medical report, the patient presents with bilateral knee pain and has been diagnosed with stable knee pain. The plan was for a CT scan of the left knee; Voltaren gel, Percocet; and an FRP. The patient showed interest in the FRP to improve her overall function and improve recovery time with pending surgery. The exam shows the patient uses a left knee brace, there is pain at the end of extension, negative effusion or crepitus. The 11/20/14 report states the patient had 2 prior surgeries on the left knee, and that the CT scan is to evaluate further osteoarthritis as the patient may be a candidate for a total knee replacement. The 11/20/14 and 8/28/14 reports did not discuss use of Voltaren gel, so it appears that it was first prescribed on 1/20/15. MTUS, pg 111-113 under Topical NSAIDs states: Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The patient is reported to have tried and failed various medications. It appears that on 1/20/15, the physician wanted to try Voltaren gel for the knee osteoarthritis. The request appears to be in accordance with MTUS guidelines. The request for Voltaren gel IS medically necessary.