

Case Number:	CM15-0056375		
Date Assigned:	04/01/2015	Date of Injury:	08/13/2013
Decision Date:	05/19/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	03/24/2015

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: 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 41-year-old male who reported an injury on 08/13/2013. The mechanism of injury was not provided. His diagnoses include unspecified internal derangement of the knee. Past treatments included physical therapy, injections, bracing, and medications. It was indicated the injured worker had been approved for a right knee operative arthroscopy with meniscectomy and chondroplasty. On 03/06/2015, it was indicated the injured worker had right knee pain despite previous modalities of conservative treatment. He reported that the pain wakes him up at night, and he has difficulty performing his activities of daily living. Upon physical examination, it was indicated the injured worker had tenderness along the right knee, as well as a positive McMurray's medially. It was also noted the injured worker had a positive compression test, and his range of motion measured 0 to 125 degrees. Medications were not listed. The treatment plan included surgery with preoperative clearance and medications. A request was received for amoxicillin 875 mg #20; Zofran 8 mg #20; Topamax 50 mg #120; Polar Care rental 7 days; and prefabricated knee brace for postoperative infection, postoperative nausea, neuropathic pain, and range of motion, respectively. The Request for Authorization was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amoxicillin 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infectious Disease, Amoxicillin (Amoxil½).

Decision rationale: According to the Official Disability Guidelines, amoxicillin is recommended as a first line treatment for cellulitis. The clinical documentation submitted for review did not indicate the injured worker had cellulitis. Although the medication is being prescribed for prophylactic use, there is no evidence of an active infection. Consequently, the request is not supported. Additionally, the request did not specify duration and frequency of use. As such, the request for amoxicillin 875 mg #20 is not medically necessary.

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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Antiemetics (for opioid nausea).

Decision rationale: According to the Official Disability Guidelines, Zofran is FDA approved for nausea and vomiting secondary to chemotherapy and radiation, and postoperative use, as well as gastroenteritis. The clinical documentation submitted for review indicated the injured worker was prescribed this medication for postoperative nausea. However, the request did not specify duration and frequency of use. Consequently, the request is not supported. As such, the request for Zofran 8 mg #20 is not medically necessary.

Topamax 50mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 21.

Decision rationale: According to the California MTUS Guidelines, Topamax is an anticonvulsant that is considered for neuropathic pain when other anticonvulsants have failed. The clinical documentation submitted for review did not indicate the failure of other anticonvulsants to warrant the use of Topamax. Consequently, the request is not supported. Additionally, the request did not specify duration and frequency of use. As such, the request for Topamax 50 mg #120 is not medically necessary.

Polar care rental 7 days: Overturned

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

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, Continuous-flow cryotherapy.

Decision rationale: According to the Official Disability Guidelines, continuous flow cryotherapy is recommended as an option after surgery for up to 7 days. The clinical documentation submitted for review indicated the injured worker had been approved for the right knee surgery. Accordingly, the request is supported by the evidence based guidelines. As such, the request for Polar Care rental 7 days is medically necessary.

Prefabricated knee brace: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg.

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, Knee brace.

Decision rationale: According to the Official Disability Guidelines, the criteria for the use of a prefabricated knee brace is knee instability, ligament insufficiency/deficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental osteoarthritis, or tibial plateau fracture. The clinical documentation submitted for review indicated the injured worker was approved for a knee arthroscopy with meniscectomy and chondroplasty. Accordingly, the request is supported by the evidence based guidelines. As such, the request for prefabricated knee brace is medically necessary.