

Case Number:	CM14-0216283		
Date Assigned:	01/06/2015	Date of Injury:	08/21/2008
Decision Date:	03/19/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/24/2014

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: New York
Certification(s)/Specialty: Neurological 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 62 year old male had a date of injury 08/21/2008. Mechanism of injury is not described. He had a left knee arthroplasty on 08/16/2013. On 2/27/2014 he was involved in a motor vehicle accident. Physical therapy was advised by examining physician. X-rays on 5/15/2014 noted the total knee replacement but no evidence of loosening of the implant. Examination showed mild knee swelling. Diagnostic impression was medial collateral left knee sprain with osteoarthritis of the knee, genu varum, status post arthroplasty. The PR2 of 9/18/2014 noted complaints of severe knee pain. The injured worker felt like his knee was going to split open. Exam showed the knee wound to be well healed, no tenderness, negative anterior and posterior drawer signs, no tenderness over medial or lateral ligaments, but some tenderness over the quadriceps and patellar tendons. He was taking Norco 10/325, Celebrex 200 mg per day, as well as Nexium, Tylenol, restoril, xartemis xr ands voltaren gel. Utilization review denied the request for left knee arthroscopy and exploration, EMGs and NCVs, outpatient physical therapy (frequency and duration not stated) as well as Xartemis 2 p.o. q 12hours and Voltaren gel 1% 3 Gms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient arthroscopy and exploration of the 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 (ODG)- knee and leg, Indications for surgery- diagnostic arthroscopy

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

Decision rationale: ODG guidelines do not recommend arthroscopic surgery for osteoarthritis. Second look arthroscopy (ODG Guidelines-Diagnostic Arthroscopy) is not be recommended unless there were complications from prior procedures. The provider has not provided evidence of such complications. Criteria for diagnostic arthroscopy include functional limitations continue despite conservative care, inconclusive imaging and failed physical therapy. Functional limitations have not been described nor the results of physical therapy. No imaging reports are presented or a rationale presented for knee exploration. Thus outpatient arthroscopy and exploration of the left knee is not appropriate or necessary.

EMG/NCV of the lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Physical Therapy-EMG, nerve conduction studies

Decision rationale: Nerve conduction studies are not recommended under ODG. The worker does not present with complains consistent with a radiculopathy and EMG would not be indicated either. The provider does not present treatment plan explaining why EMGs and nerve conduction times are required.

Outpatient physical therapy for the left knee (frequency and duration not provided):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Physical Therapy should be prescribed under guidelines. Frequency and duration is not given and thus would not be approved.

Decision rationale: ODG guidelines recommend physical therapy be delivered in individually designed exercise programs. Documentation does not provide evidence this is requested. ODG guidelines indicate that successful outcomes depend on functional restoration program. Documentation does not show such a program is being requested. Furthermore, Physical Therapy

should be prescribed under time and frequency and location recommendations which is lacking in the documentation. Thus this request is not appropriate or necessary due to its limitations.

Xartemis Xr 2 po q 12 hours: 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), Pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Establish a Therapeutic plan, Steps to take before a therapeutic trial of opioids, initiating ther.

Decision rationale: Documentation does not provide evidence that the California MTUS guidelines are being followed to establish a therapeutic plan. There is no evidence of directions to initiate therapy to provide the smallest dose for the shortest time. There is no evidence for ongoing management. Thus this request is not appropriate or necessary.

Voltaren gel 1% 3grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: Documentation does not show the lowest dose for the shortest time period of the NSAID Voltaren has been established in this worker's therapy. Documentation does not show that possible side effects have been appreciated. ODG guidelines (Pain Chapter-Voltaren gel) note it is not recommended as a first line treatment Thus Voltaren Gel is not medically necessary or appropriate.