

Case Number:	CM15-0110328		
Date Assigned:	06/16/2015	Date of Injury:	03/11/2012
Decision Date:	07/15/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/08/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 46 year old male, who sustained an industrial injury on March 11, 2012. Treatment to date has included modified work duty, arthroscopic surgery, work hardening, physical therapy, acupuncture and home exercise, and medications. Currently, the injured worker complains of continued left ankle pain and left knee pain. He reports that he ankle pain is increased with standing and walking and he rates his ankle pain 1-5 on a 10-point scale. He reports that his standing and walking are limited to 30 minutes and his sitting is limited to two hours. He reports deep burning pain at the interior joint line both medially and laterally. The injured worker reported improvement in pain with blocks. He reported that his knee pain is becoming progressively more painful and tender and he has limping on the left side. On physical examination the injured worker's left ankle is grossly stable and he has a slight limp with weight-bearing. The diagnoses associated with the request includes left ankle contusion with bony edema, syndesmotoc ligament sprain, status post arthroscopy with probable hypertrophic synovitis, calcaneal fibular ligament tear, partial deltoid ligament tear, ATFL tear, post-traumatic chondromalacia, and probable cutaneous neuropathy. The treatment plan includes work restrictions, MRI of the right knee, pain management follow-up and compounding cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Right Ankle: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG MRI Foot and Ankle.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 373-374.

Decision rationale: The ACOEM chapter on ankle complaints and imaging states: Radiographic evaluation may also be performed if there is rapid onset of swelling and bruising; if patient's age exceeds 55 years; if the injury is high velocity; in the case of multiple injury or obvious dislocation/subluxation; or if the patient cannot bear weight for more than four steps. For patients with continued limitations of activity after four weeks of symptoms and unexplained physical findings such as effusion or localized pain, especially following exercise, imaging may be indicated to clarify the diagnosis and assist reconditioning. Stress fractures may have a benign appearance, but point tenderness over the bone is indicative of the diagnosis and a radiograph or a bone scan may be ordered. Imaging findings should be correlated with physical findings. Disorders of soft tissue (such as tendinitis, metatarsalgia, fasciitis, and neuroma) yield negative radiographs and do not warrant other studies, e.g., magnetic resonance imaging (MRI). Magnetic resonance imaging may be helpful to clarify a diagnosis such as osteochondritis dissecans in cases of delayed recovery. Cases of hallux valgus that fail conservative treatment merit standing plain films to plan surgery, and consultation with the potential surgeon is recommended. Sprains are frequently seen after emergency room treatment in which radiographs are obtained to rule out fractures. Minimal sprains can be treated symptomatically without films. Table 14-5 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. These criteria for MRI have not been met in the provided clinical documentation and therefore the request is not medically necessary.

Pain Management Follow-up: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment.

Decision rationale: Per the ACOEM :The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient has ongoing pain despite conservative therapy. Therefore follow up consult with pain management is medically necessary.

Topical Compound Cream: Upheld

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

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

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenicamines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains ingredients that are not specified which are not indicated per the California MTUS for topical analgesic use. Therefore the request is not medically necessary.