

Case Number:	CM15-0032420		
Date Assigned:	02/25/2015	Date of Injury:	10/22/1997
Decision Date:	05/13/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	02/20/2015

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 63-year-old male who reported an injury on 10/22/1997. The mechanism of injury was not provided. His diagnosis is noted as internal derangement of knee. During the assessment on 12/29/2014, the injured worker was in for a follow-up to review the MRI results of the left knee. The MRI was noted to reveal tricompartmental osteoarthritis as well as a lateral meniscus tear. The physical examination was noted to reveal tenderness to palpation at the lateral joint line. There was full range of motion with pain upon deep flexion. Strength and stability were within normal limits. Upon physical examination of the lumbar spine there were spasms noted with limited range of motion. A cortisone injection to the left knee was performed during the office visit. The treatment plan included recommendations for oral and transdermal anti-inflammatory and analgesic medications, physical therapy, an MRI of the left knee, and a cortisone injection to the left knee under fluoroscopy and ultrasound. The rationale for the request was not provided. The Request for Authorization form was dated 01/08/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left knee cortisone injection under fluoroscopy and ultrasound: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346-347. Decision based on Non-MTUS Citation Official Disability Guidelines- Knee & Leg.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Corticosteroid injections.

Decision rationale: The request for left knee cortisone injection under fluoroscopy and ultrasound is not medically necessary. The California MTUS/ACOEM Guidelines state that invasive techniques, such as needle aspiration of effusions or prepatellar bursal fluid and cortisone injections, are not routinely indicated. Knee aspirations carry inherent risk and subsequent intra-articular infection. The Official Disability Guidelines indicate the criteria for intra-articular glucocorticosteroid injection include bony tenderness, crepitus, and pain interferes with functional activities. The guidelines also indicate that the injections are generally performed without fluoroscopic or ultrasound guidance. The physical examination did not indicate that there was any bony enlargement, or crepitus. There was no indication that the pain interfered with functional activities. Additionally, the request as submitted indicated that the injection was to be performed under fluoroscopy and ultrasound, and the guideline specifically indicates that the injections are generally performed without fluoroscopic or ultrasound guidance. As such, the request is not medically necessary.

MRI of the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The California MTUS/ACOEM Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. If the physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of imaging test to identify a potential cause. However, the clinical documentation did not include a physical examination of the lumbar spine. The rationale for the requested MRI of the lumbar spine was not provided. As such, the request is not medically necessary.

Physical therapy for the left knee and lumbar spine utilizing iontophoresis and H wave #6:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for physical therapy for the left knee and lumbar spine utilizing iontophoresis and H-wave #6 is not medically necessary. The California MTUS Guidelines do not recommend the H-wave unit as an isolated intervention. It may be considered a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation if used as an adjunct to a program of evidence based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation (TENS). The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines recommend up to 10 visits of physical therapy. The clinical documentation did not indicate if the injured worker had previously attended physical therapy, with the number of completed therapy visits. There was no indication that the physical therapy was going to be used as an adjunct to the H-wave unit. Due to the lack of information regarding the specific short and long-term goals of treatment and documentation of any prior treatment, the request is not medically necessary.

Flurbiprofen 20% cream 30gm: Upheld

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

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

Decision rationale: The request for flurbiprofen 20% cream 30 gm is not medically necessary. The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state that any compound product that contains at least 1 drug that is not recommended, is not recommended. The requested cream contains flurbiprofen. The guidelines state that topical NSAIDS may be useful for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4 to 12 weeks). There is little evidence to utilize topical NSAIDS for treatment of osteoarthritis of the spine, hip or shoulder. The use of topical NSAIDS is not recommended for neuropathic pain as there is no evidence to support the use. The clinical documentation did not indicate that the injured worker had osteoarthritis or tendinitis to a joint amenable to topical treatment to justify the need for a topical NSAID. There was a lack of subjective complaints of neuropathic pain and adequate documentation regarding failure of antidepressant and anticonvulsants. There was no rationale indicating why the injured worker would require a topical cream versus oral medication. The quantity, frequency and application site for the proposed medication was also not provided. Given the above, the request is not medically necessary.

Gabapentin 10% cream 20gm: Upheld

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

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

Decision rationale: The request for gabapentin 10% cream 20 gm is not medically necessary. The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state that any compound product that contains at least 1 drug that is not recommended, is not recommended. The requested topical cream contains gabapentin. Topical gabapentin is not recommended by the guidelines, as there is no evidence to support the use. There was also a lack of subjective complaints of neuropathic pain and adequate documentation regarding failure of antidepressant and anticonvulsants. Additionally, the quantity, frequency and application site for the purposed medication was also not provided. Given the above, the request is not medically necessary.

Cyclobenzaprine 10% cream 30gm: Upheld

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

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

Decision rationale: The request for cyclobenzaprine 10% cream 30 gm is not medically necessary. The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state that any compound product that contains at least 1 drug that is not recommended, is not recommended. The requested topical cream contains gabapentin. Topical cyclobenzaprine is not recommended by the guidelines, as there is no evidence to support the use. There was also a lack of subjective complaints of neuropathic pain and adequate documentation regarding failure of antidepressant and anticonvulsants. Additionally, the quantity, frequency and application site for the purposed medication was also not provided. Given the above, the request is not medically necessary.