

Case Number:	CM15-0064073		
Date Assigned:	04/10/2015	Date of Injury:	07/25/2013
Decision Date:	05/14/2015	UR Denial Date:	03/28/2015
Priority:	Standard	Application Received:	04/03/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic 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:

The injured worker is a 46-year-old male who sustained an industrial injury on 7/25/13, relative to a twisting injury. Past surgical history was positive right knee anterior cruciate ligament (ACL) reconstruction in 1994. The 11/5/13 right knee MRI impression documented the injured worker was status post ACL reconstruction with integrity difficult to confirm. The medial meniscus was consistent with previous partial medial meniscectomy, with possible small amount of displaced meniscal tissue. There was blunting of the inner surface of the lateral meniscus, which could be related to previous partial meniscectomy or inner surface tearing. There was irregular medial and lateral compartment chondrosis, more severe in the medial compartment, and a focal area of high grade chondrosis affecting the posterior meniscal surface of the lateral femoral condyle. There was irregular patellofemoral joint chondrosis that appeared most severe at the medial trochlea. A small joint effusion was present. There were irregular osseous hypertrophic changes along the tibial spines, most likely post-surgical but a small anterior articular body would not be completely excluded. The 3/11/15 treating physician report cited worsening grade 8/10 right knee pain, increased grinding, and the injured worker felt something was protruding out. Pain was worse at night and with activity. There was popping and locking. He wore a right knee brace which was helpful while walking. The current medications included Naproxen, Tramadol, Cyclobenzaprine, Omeprazole, and Voltaren gel from another provider. Medications, home exercise program, rest, ice, compression, elevation, and TENS unit were helpful for pain control. Physical exam documented cracking and popping of the right knee laterally with flexion and extension, and ambulation with more weight on the right. The

diagnosis included right knee sprain/strain. The treatment plan requested an updated MRI of the right knee due to persistent and worsening pain, and right total knee arthroplasty per the orthopedic surgeon and PQME recommendations. Medications were prescribed to include Voltaren 1% gel for pain control and cyclobenzaprine 7.5 mg #60 for muscle relaxation of right knee spasms. Additional medications included Tramadol, Naproxen, and omeprazole. The 3/28/15 utilization review non-certified the request for right total knee arthroplasty as guideline criteria had not been met relative to no evidence of range of motion less than 90 degrees, the patient was not over 50 years of age, and updated imaging was pending. The request for Voltaren gel was non-certified as records indicated that this was being provided by another provider and additional prescription was not medically necessary. The request for cyclobenzaprine was non-certified, as the injured worker had been using this medication since at least December 2013, which exceeds guideline recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) right knee total arthroplasty: 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 & Leg (Acute & Chronic).

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

Decision rationale: The California MTUS does not provide recommendations for total knee arthroplasty. The Official Disability Guidelines recommend total knee replacement when surgical indications are met. Specific criteria for knee joint replacement include exercise and medications or injections, limited range of motion (< 90 degrees), night-time joint pain, no pain relief with conservative care, documentation of functional limitations, age greater than 50 years, a body mass index (BMI) less than 40, and imaging findings on standing x-rays or previous arthroscopy of osteoarthritis. Guideline criteria have not been met. This injured worker presents with right knee pain, popping, and locking. Clinical exam findings documented cracking and popping with range of motion. However, there is no documentation of range of motion limitation, specific functional limitations, or body mass index. There is no documentation of standing x-ray evidence of osteoarthritis noted in the provided records. An updated MRI was certified and pending. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including injections, and failure has not been submitted. Additionally, this patient is not over 50-years of age. Therefore, this request is not medically necessary.

One (1) prescription of voltaren 1% gel with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal inflammatory agents).

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

Decision rationale: The California MTUS states that topical Voltaren is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Guidelines support short-term use (4 to 12 weeks). Guideline criteria have not been met. This injured worker has been prescribed Voltaren gel since at least December 2013 with no documentation of a specific pain or functional benefit. There is no guideline support for long-term use. Therefore, this request is not medically necessary.

One (1) prescription of Cyclobenzaprine 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Muscle relaxants (for pain) Page(s): 41-42, 63-65.

Decision rationale: The California MTUS guidelines recommend the use of cyclobenzaprine (Flexeril) as an option, using a short course of therapy, in the management of back pain. Treatment should be brief. This medication is not recommended to be used for longer than 2 to 3 weeks. Guideline criteria have not been met for continued use. Records indicate that this medication has been prescribed since at least December 2013. There is no documentation of specific functional benefit associated with the patient's use of this medication or current evidence of muscle spasms. Given the absence of guideline support beyond 2 to 3 weeks, discontinuation is indicated. Therefore, this request is not medically necessary.