

Case Number:	CM13-0016307		
Date Assigned:	11/06/2013	Date of Injury:	11/29/2008
Decision Date:	01/17/2014	UR Denial Date:	08/19/2013
Priority:	Standard	Application Received:	08/27/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 56-year-old female who reported an injury on 11/29/2008 due to a combative patient. The patient sustained an injury to the right knee. The conservative treatments included medication, physical therapy, and corticosteroid injections. Due to continued pain complaints, the patient received acupuncture, massage, heating, and herbal treatments. The patient's most recent evaluation revealed constant right knee pain rated at a 4/10. It was noted that the patient was wearing a knee brace. The patient had limited range of motion of the right knee and reported mechanical symptoms. The physical findings included mild crepitation with range of motion, tenderness along the medial and lateral joint lines, positive compression test, tenderness along the inner patella region, external rotation at 60 degrees on the right and 60 degrees on the left. The patient's diagnoses included internal derangement of the right knee with evidence of lateral meniscus tear by MRI, weight loss of estimated 15 pounds, and sleep dysfunction. The patient's treatment plan included continuation of medications, corticosteroid injection of the right knee, a hinged knee brace, a TENS unit, hot/cold therapy, and additional physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Section Page(s): 68-69.

Decision rationale: The requested Naproxen 550mg #60 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has persistent knee complaints. However, the California Medical Treatment and Utilization Schedule states, "A non-pharmacological choice should be the first option in patients with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short-term needs. An opioid also remains a short-term alternative for analgesia." The patient's failure to respond to first line pain medications is not supported within the documentation. The patient's condition is complicated by hypertension and diabetes. Therefore, documentation of non-pharmacological choices and failure to respond to acetaminophen or aspirin would be recommended. As such, the requested Naproxen 550mg #60 is not medically necessary or appropriate.

Prilosec 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Section Page(s): 68-69.

Decision rationale: The requested Prilosec 20mg #60 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has continued knee pain complaints. The California Medical Treatment and Utilization Schedule recommend the use of a gastrointestinal protectant when the patient is at risk for serious gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide any evidence that the patient has a history or current symptoms that would support the need for a gastrointestinal protectant. As such, the requested Prilosec 20mg #60 is not medically necessary or appropriate.

Acetadryl 25/500mg #50: 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 Chapter, Compound Drugs.

Decision rationale: The requested Acetadryl 25/500mg #50 is not medically necessary or appropriate. The patient does have continued pain complaints of the right knee. The Official Disability Guidelines do not recommend compounded drugs unless the patient has failed to respond to first line medications. The clinical documentation submitted for review does not

provide evidence that the patient's pain has been non-responsive to first line treatments. As such, the requested Acetadryl 25/500mg #50 is not medically necessary or appropriate.

Terocin Lotion 4oz: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Section Page(s): 111.

Decision rationale: The requested Terocin Lotion 4 oz is not medically necessary or appropriate. The patient does have continued pain complaints of the right knee. The requested Terocin cream contains methyl salicylate, capsaicin, menthol, and lidocaine. The California Medical Treatment and Utilization Schedule does recommend the use of methyl salicylate and menthol as a topical agent. However, the use of Capsaicin is only recommended for patients who are intolerant or unresponsive to other treatments. The clinical documentation submitted for review does not provide any evidence that the patient has been unresponsive or intolerant to other treatments. Additionally, the California Medical Treatment and Utilization Schedule states, "no other commercially approved topical formulation of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain." Also, lidocaine is not recommended for non neuropathic pain. Additionally, the California Medical Treatment and Utilization Schedule recommend the introduction of pain medications for the management of chronic pain be introduced 1 at a time. Therefore, a formulation of medication with multiple medications would not be indicated. Additionally, any compounded agent that contains an element that is not recommended by Guidelines is not supported. As such, the requested Terocin Lotion 4 oz is not medically necessary or appropriate.

Medrox patch (Qty: 20): Upheld

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

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

Decision rationale: The requested Medrox Patches QTY: 20 are not medically necessary or appropriate. The patient does have continued knee complaints of pain. The requested medication contains menthol and Capsaicin. The California Medical Treatment and Utilization Schedule does not recommend capsaicin as a topical agent unless there is documentation that the patient has failed to respond to oral medications. The clinical documentation submitted for review does not provide evidence that the patient has failed to respond to oral medications. As such, the requested Medrox Patches QTY: 20 are not medically necessary or appropriate.

Corticosteroid Injection to the right 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Corticosteroid Injections.

Decision rationale: The requested Corticosteroid Injection - right knee is not medically necessary or appropriate. The patient does have continued pain complaints of the right knee. The American College of Occupational and Environmental Medicine does recommend corticosteroid injections as an option in the treatment of a patient's pain. However, the Official Disability Guidelines recommend the use of corticosteroid injections after the patient has failed to respond to medications and active therapy. The clinical documentation submitted for review does not provide any evidence that the patient has received any recent active therapy or is participating in a home exercise program. As such, the requested Corticosteroid Injection - right knee is not medically necessary or appropriate.

TENS Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 114.

Decision rationale: The requested TENS Unit is not medically necessary or appropriate. The patient does have persistent right knee pain complaints. The California Medical Treatment and Utilization Schedule recommends the purchase of a TENS unit after a 30-day trial has produced significant functional gains. Additionally, this treatment modality is not recommended as a standalone treatment. The clinical documentation submitted for review does not provide any evidence that the patient is currently participating in physical therapy or a home exercise program that would benefit from the use of a TENS unit. As such, the requested TENS Unit is not medically necessary or appropriate.

Hot/Cold Unit: 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). Knee and Leg Chapter, Continuous Flow Cryotherapy.

Decision rationale: The requested Hot/Cold Unit is not medically necessary or appropriate. The patient does have persistent pain complaints of the right knee. The Official Disability Guidelines do not recommend the use of a cryotherapy unit in the absence of surgical intervention. The

clinical documentation submitted for review does not provide any evidence that the patient has undergone surgical repair of the right knee. Therefore, this type of therapy would not be indicated. As such, the requested Hot/Cold Unit is not medically necessary or appropriate.