

Case Number:	CM13-0028124		
Date Assigned:	12/11/2013	Date of Injury:	06/18/2012
Decision Date:	03/12/2014	UR Denial Date:	08/29/2013
Priority:	Standard	Application Received:	09/23/2013

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 & 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 43-year-old male who reported an injury on 06/18/2012 due to a lifting injury that reportedly caused injury to his low back and knee. Previous treatments have included pain medications, bracing, a TENS unit, a home exercise program, psychotherapy, chiropractic care, physical therapy, and injection therapy. The patient underwent a right knee lateral meniscectomy and medial parapatellar plica resection on 07/08/2013. The patient's most recent clinical examination findings included that the patient was being provided Norco and Theramine for pain postoperatively, and the patient continued to have assisted ambulation with crutches. The patient's treatment plan was to continue Norco and Theramine, and begin postoperative therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 60 and 74.

Decision rationale: The requested hydrocodone 10/325 #60 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been prescribed this medication for postoperative pain. California Medical Treatment Utilization Schedule recommends medications that are used in the management of a patient's pain be supported by functional benefit and quantitative assessment of pain relief. The clinical documentation submitted for review does not provide any evidence that this medication is providing pain relief or any functional benefit. Therefore, continued use would not be supported. As such, the requested hydrocodone 10/325 mg #60 is not medically necessary or appropriate.

2 prescriptions of Naproxen 250mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60 and.

Decision rationale: The requested naproxen 250 mg #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of medications in the management of a patient's chronic pain be supported by documentation of functional benefit and documentation of a quantitative pain assessment to support the efficacy of the prescribed medication. The clinical documentation submitted for review does not provide any evidence that the patient is receiving any pain relief or functional benefit from the requested medication. Additionally, the requested 2 prescriptions does not allow for timely re-evaluation to determine the efficacy of the medication to support continued use. As such, the requested 2 prescriptions of naproxen 250 mg #60 are not medically necessary or appropriate

3 prescriptions of Theramine #90: Upheld

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

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, Theramine.

Decision rationale: The requested Theramine #90 for 3 prescriptions is not medically necessary or appropriate. Official Disability Guidelines does not recommend the use of Theramine, as there is little scientific data to support the efficacy and safety of this medication. The clinical documentation submitted for review does provide evidence that the patient was previously prescribed this medication. The California Medical Treatment Utilization Schedule recommends medications be supported by a quantitative assessment of pain relief and functional benefit. The clinical documentation submitted for review does not provide any evidence that this medication provides any pain relief or functional benefit to support extending treatment beyond guideline

recommendations. As such, the requested Theramine with 3 refills is not medically necessary or appropriate.

1 Neoprene sleeve for right knee: Upheld

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

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, Knee Brace.

Decision rationale: The requested 1 neoprene sleeve for the right knee is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has previously used a hinged knee brace. The clinical documentation does not provide any evidence that the previously used knee brace would not be sufficient to provide relief to this patient. Additionally, Official Disability Guidelines does not recommend the use of a knee brace after this type of surgical intervention. Therefore, the need for a neoprene sleeve for the right knee is not clearly established. As such, the requested 1 neoprene sleeve for the right knee is not medically necessary or appropriate.

Unknown Terocin lotion: 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 Topical Analgesics Page(s): 111.

Decision rationale: The requested Terocin lotion is not medically necessary or appropriate. Terocin is a compounded agent that contains methyl salicylate, capsaicin, menthol, and lidocaine. The California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol as a topical agent for osteoarthritic pain. The clinical documentation submitted for review does not provide any evidence that the patient's pain is related to osteoarthritis. The California Medical Treatment Utilization Schedule does recommend the use of capsaicin for patients who are intolerant or unresponsive to other treatments. The clinical documentation does not support that the patient has been unresponsive or intolerant to the most recent surgical intervention. Therefore, the use of capsaicin would not be supported. Also, the California Medical Treatment Utilization Schedule does not support the use of lidocaine in a cream formulation, as it is not FDA-approved for neuropathic pain. The California Medical Treatment Utilization Schedule does not recommend the use of any compounded agent that has at least 1 drug (or drug class) that is not supported by guideline recommendations. As such, the requested Terocin lotion is not medically necessary or appropriate.

Unknown physical therapy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: The requested physical therapy is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of postoperative physical therapy for patients who have undergone a meniscectomy. The recommended number of visits is 12 postoperative physical therapy visits to include an initial course of therapy to establish the efficacy for continued use of this treatment modality. Although an initial course of therapy for this patient to include 6 visits of physical therapy would be supported, the request, as it is written, does not clearly define the frequency or duration of postoperative physical therapy. As such, the requested unknown physical therapy is not medically necessary or appropriate.