

Case Number:	CM14-0168514		
Date Assigned:	10/16/2014	Date of Injury:	12/06/2013
Decision Date:	11/25/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/13/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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/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:

According to the records made available for review, this is a 41-year-old male with a 12/6/13 date of injury. At the time (10/10/14) of Decision for Retro Tramadol 50MG 1 TAB TID #90 and Retro Mentherm Gel 4 OZ # 1, there is documentation of subjective (low back and right knee pain) and objective (tenderness to palpitation over the medial and lateral joint line of the right knee and positive McMurray sign) findings, current diagnoses (knee meniscus tear, knee derangement of medial meniscus, and lumbar sprain/strain), and treatment to date (physical therapy and medications (including ongoing treatment with Tramadol since at least 5/1/14)). Regarding Retro Tramadol 50MG, there is no documentation of moderate to severe pain, Tramadol used as a second-line treatment; the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Tramadol use to date. Regarding Retro Mentherm Gel 4 OZ, there is no documentation of a trial of antidepressants and anticonvulsants have failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO TRAMADOL 50MG 1 TAB TID #90: 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): 74-80 113. Decision based on Non-MTUS Citation Title 8, California Code of Regulations.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; as criteria necessary to support the medical necessity of Opioids. In addition, specifically regarding Tramadol, MTUS Chronic Pain Medical Treatment Guideline identifies documentation of moderate to severe pain and Tramadol used as a second-line treatment (alone or in combination with first-line drugs), as criteria necessary to support the medical necessity of Tramadol. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of knee meniscus tear, knee derangement of medial meniscus, and lumbar sprain/strain. However, despite documentation of pain, there is no (clear) documentation of moderate to severe pain. In addition, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and Tramadol used as a second-line treatment. Furthermore, given documentation of ongoing treatment with Tramadol, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Tramadol use to date. Therefore, based on guidelines and a review of the evidence, the request for Retro Tramadol 50MG 1 TAB TID #90 is not medically necessary.

RETRO MENTHODERM GEL 4 OZ # 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation <http://www.drugs.com/cdi/menthoderm-cream.html>

Decision rationale: Medical Treatment Guideline identifies Menthoderm cream as a topical analgesic containing Methyl Salicylate and Menthol. MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when trial of antidepressants and anticonvulsants have failed, as criteria necessary to support the medical necessity of topical analgesics. Within the medical information available for review, there is documentation of diagnoses of knee meniscus tear, knee derangement of medial meniscus, and lumbar sprain/strain. In addition, there is documentation of neuropathic pain. However, there is no

documentation of a trial of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for Retro Methoderm Gel 4 oz. # 1 is not medically necessary.