

Case Number:	CM14-0178584		
Date Assigned:	10/29/2014	Date of Injury:	04/16/2013
Decision Date:	12/18/2014	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/23/2014

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 Emergency Medicine and is licensed to practice in 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 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:

The injured worker is a 65-year-old male who reported an injury on 04/16/2013. The mechanism of injury was pulling. The injured worker's diagnoses included left knee complex medial and lateral meniscus tears, left knee anterior cruciate ligament full thickness tear with severe tricompartmental osteoarthritis and severe joint space narrowing. The injured worker's past treatments included physical therapy, injections, and medications. The injured worker's diagnostic testing included x-rays of the left knee and of the left tibia, which were noted to show no loosening of the TKA. The injured worker's surgical history included a right shoulder arthroscopy in 07/2012 and a left total knee arthroplasty on 03/21/2014. On 07/14/2014, the injured worker reported improvement to his left knee with range of motion as a result of therapy. He reported some post-operative pain in his left knee. Upon physical examination, the injured worker was noted with improvement with range of motion. The injured worker's medications included hydrocodone/APAP 10/325 mg, Orphenadrine citrate ER 100 mg, Diclofenac sodium ER 100 mg, and Pantoprazole sodium ER 20 mg. The request was for a urine toxicology screen and IF unit and supplies (rental). The rationale for the requests was not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine toxicology screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: The request for a urine toxicology screen is not medically necessary. According to the California MTUS Guidelines, drug testing may be recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The documentation indicates that a urine toxicology screen was performed as recently as 01/2014. The injured worker was not documented to have any potentially aberrant drug related behaviors to warrant more frequent urine toxicology screen. The previous urine toxicology screen indicated that the patient was consistent with prescribed medications. The injured worker was noted to have been using opioid therapy since at least 2013. In the absence of documentation with sufficient evidence of occurrence or suspicion of any potentially aberrant drug related behaviors, or a clear rationale for a more frequent urine toxicology screen for this injured worker, the request is not supported. Therefore, the request is not medically necessary.

IF Unit & supplies (rental): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: The request for an IF Unit & supplies (rental) is not medically necessary. According to the California MTUS Guidelines, IF units are not recommended as an isolated intervention. There is no quality evidence of effectiveness, except in conjunction with recommended treatments, including return to work, exercise, and medications, and limited evidence of improvement on those treatments alone. For those patients with documented evidence that pain is ineffectively controlled due to diminished effectiveness of medications; pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or unresponsiveness to conservative measures (to include physical therapy, home exercise program, and medications), then a 1 month trial may be appropriate. There should be evidence of increased functional improvement, less reported pain, and evidence of medication reduction. The injured worker complained of postoperative left knee pain. He reported doing better with physical therapy. The documentation did not provide sufficient evidence of tried and failed conservative therapy, uncontrolled pain due to diminished effectiveness of medications or due to side effects, or documented evidence of a 1 month trial. In the absence of documentation with sufficient evidence of tried and failed conservative therapy, uncontrolled pain due to diminished effectiveness of medications or due to side effects, or documented evidence of a 1 month trial with evidence of increased functional improvement, the request is not supported. Therefore, the request is not medically necessary.

