

Case Number:	CM14-0023701		
Date Assigned:	06/11/2014	Date of Injury:	06/17/2013
Decision Date:	07/28/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/25/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 59 year old male who reported an injury on 06/17/2013 due to bumping his knee. On 01/20/2014 he reported pain in the right knee with numbness down the right leg to the foot when walking, lying down, and driving. He also reported pain from the left shoulder down to the left arm with numbness. He rated his pain at 7/10. A physical examination revealed bilateral 2 plus reflexes in the biceps, triceps, knees and ankles; straight leg raise, clonus, lhermitte's sign, and spurling's sign were all negative bilaterally. Range of motion to the knees showed flexion of 150 degrees and extension of 0 degrees bilaterally. Shoulder range of motion showed flexion, extension, abduction, adduction, internal rotation, and external rotation were all within normal limits. An X-ray of the right knee dated 06/18/2013 showed minimal pointing at superior, posterior, and inferior patella and very minimal smooth degenerative change along upper anterior patella, but otherwise unremarkable. Also, an MRI of the right knee performed on 10/02/2013 showed medial meniscal tear with narrowing of the medial compartment and possible anterior cruciate ligament sprain. Diagnoses included right knee contusion, internal derangement with medial meniscus tear, left shoulder sprain, and history of lumbar spine complaints from a previous injury. The current medications included Acetaminophen, nabumetone, and tramadol with unspecified doses and frequencies. Prior therapies were not provided. The treatment plan was for Napro Cream 15% #240 and Theramine #60. The request for authorization and rationale for treatment were not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Napro Cream 15% #240: Upheld

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

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

Decision rationale: The injured worker was noted to have right knee and left shoulder pain due to his work related injury. The MTUS Chronic Pain Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain. Topical NSAIDs are used for short term relief (4-12 weeks). The clinical information provided for review does not indicate that the injured worker's pain was caused by neuropathy. The rationale for the use of the medication and/or length of treatment was not stated. In addition, there is no evidence of pain relief or functional improvement with the use of the medication to determine efficacy. Furthermore, the requesting physician did not specify the frequency or site of application within the request. As such, the request is not medically necessary and appropriate.

Theramine #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter, Theramine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Medications (Pain), Medical Food and Pain, Theramine.

Decision rationale: Theramine is listed as a medical food. The Official Disability Guidelines state that to be considered the product must meet the following criteria: be a food for oral or tube feeding; the product must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be used under medical supervision. The ODG further states, Theramine is not recommended due to the lack of high quality studies of the ingredients in Theramine. The requesting physician did not provide a rationale for the use of this specific medication. In addition, the documentation provided did not indicate that the medical food would be given under medical supervision. Furthermore, the frequency of the medical food was not provided within the request. The request is not supported by the ODG recommendations. As such, the request is not medically necessary and appropriate.