

<b>Case Number:</b>	CM14-0071006		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	08/19/2013
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	04/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/16/2014

### 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 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:

The injured worker is a 28 year old male who sustained an injury on August 19, 2013. He is diagnosed with (a) right knee sprain/strain with magnetic resonance imaging findings of osteochondral defect at the lateral femoral condyle and ruled out internal derangement and (b) antalgic gait with mechanical low back pain and ruled out herniated lumbar disc with radiculitis/radiculopathy. He was seen on November 1, 2013 and January 29, 2014 for re-evaluation. He complained of right knee pain, which was aggravated by walking. An examination of the right knee revealed limited range of motion. McMurray's test and Apley's test were positive. Medial tenderness was noted. There was medial and lateral joint line tenderness on the right. Chondromalacia patellar test was positive on the right. Norco was renewed for severe pain. Prilosec was renewed as well for gastritis secondary to non-steroidal anti-inflammatory drugs intake. Anaprox was prescribed for inflammation and naproxen was also dispensed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

**Decision rationale:** According to the California Medical Treatment Utilization Schedule guidelines, a therapeutic trial of opioids should not be employed until the injured worker has failed a trial of non-opioid analgesics. Based on the records reviewed, there was no mention of any contraindications for use of first-line medications for pain or whether the injured worker failed a trial of non-opioid analgesics. Therefore, the request for Norco #120 is not considered medically necessary at this time.

**Naproxen (Anaprox) #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drug) Page(s): 73.

**Decision rationale:** According to the California Medical Treatment Utilization Schedule guidelines, Naproxen is indicated for osteoarthritis or ankylosing spondylitis. The diagnoses of the injured worker do not include osteoarthritis or ankylosing spondylitis. Therefore, Naproxen #120 is not considered medically necessary at this time.

**Prilosec:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPIs (proton pump inhibitors).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** It was determined from the medical records that this medication was prescribed for gastritis secondary to non-steroidal anti-inflammatory drugs intake. However, there was no documentation of any subjective complaints of gastrointestinal events secondary to medication intake as required by the California Medical Treatment Utilization Schedule guidelines. More so, there was nothing mentioned in the medical records reviewed noting that the injured worker has a significant history of peptic ulcer, gastrointestinal bleeding or perforation. Therefore, the request for Prilosec is not medically necessary at this time.

**Ambien #30 (x1refill):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-Benzodiazepine Hypnotic.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Zolpidem (Ambien).

**Decision rationale:** According to Official Disability Guidelines, Ambien is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term treatment (usually two to six weeks) of insomnia. There was no indication in the medical records why this medication was prescribed. Also, there was no complaint of sleeping difficulties noted from the injured worker to consider this medication request. Therefore, the request for Ambien #30 is not medically necessary at this time.

**Prime Interferential Unit:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Interferential current stimulation (ICS).

**Decision rationale:** The Official Disability Guidelines state that interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, medications and limited evidence of improvement on those recommended treatments alone. There was no indication that the injured worker's pains were ineffectively controlled with medications or if conservative measures such as repositioning, heat/ice and medications have been provided but have failed to warrant the use of this modality. Therefore, the request for interferential unit is not medically necessary at this time.

**IF Unit Supplies x 2 months: Electrodes, Batteries, Lead Wire:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Interferential current stimulation (ICS).

**Decision rationale:** The request for interferential unit supplies is not medically necessary at this time. As the request for interferential unit was deemed unnecessary based on Official Disability Guidelines, the request for supplies is not considered medically necessary as well.