

Case Number:	CM15-0149755		
Date Assigned:	08/13/2015	Date of Injury:	08/01/2003
Decision Date:	09/21/2015	UR Denial Date:	07/20/2015
Priority:	Standard	Application Received:	08/03/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Emergency Medicine

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 74 year old, male who sustained a work related injury on 8-1-03. The diagnosis has included status post left knee arthroscopy. Treatments have included oral medications, topical pain patches and topical pain cream-gel. In the PR-2 dated 4-13-15, the injured worker reports mild knee pain. He is status five weeks post left knee arthroscopy. He has full range of motion in left knee. He has some tenderness at the medial and lateral joint lines. He is not working. The treatment plan includes refills of medications and a request for an interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patches #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

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

Decision rationale: California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants." The injured worker has mild knee pain. He is status five weeks post left knee arthroscopy. He has full range of motion in left knee. He has some tenderness at the medial and lateral joint lines. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Terocin patches #60 are not medically necessary.

IF unit (indefinite use): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation Page(s): 118-120.

Decision rationale: The requested IF unit (indefinite use), is not medically necessary. CA Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120, noted that this treatment 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 and medications, and limited evidence of improvement on those recommended treatments alone... There are no published randomized trials comparing TENS to Interferential current stimulation; and the criteria for its use are: "Pain is ineffectively controlled due to diminished effectiveness of medications; or; Pain is ineffectively controlled with medications due to side effects; or; History of substance abuse; or; Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or; Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)." The injured worker has mild knee pain. He is status five weeks post left knee arthroscopy. He has full range of motion in left knee. He has some tenderness at the medial and lateral joint lines. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The criteria noted above not having been met, IF unit (indefinite use) is not medically necessary.

Ketoprofen 15% Lidocaine 5% gel #60 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

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

Decision rationale: The requested Ketoprofen 15% Lidocaine 5% gel #60 ml, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has mild knee pain. He is status five weeks post left knee arthroscopy. He has full range of motion in left knee. He has some tenderness at the medial and lateral joint lines. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Ketoprofen 15% Lidocaine 5% gel #60 ml is not medically necessary.