

<b>Case Number:</b>	CM15-0091451		
<b>Date Assigned:</b>	07/20/2015	<b>Date of Injury:</b>	11/30/2009
<b>Decision Date:</b>	08/13/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2015

### 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: Preventive Medicine, Occupational 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 49 year-old female patient who sustained an industrial injury on 11/30/2009. A primary treating office visit dated 07/20/2012 reported the patient with subjective complaint of right knee pain. She is status post right knee surgery on 08/06/2010. She is working and using the application of ice for comfort after work along with Alleve as needed. The following diagnoses were applied: knee strain. The plan of care involved discontinuing use of Naprosyn and prescribed Motrin and new knee sleeve. The patient is to go back to regular work duty 08/10/2012. A recent primary treating office visit dated 04/29/2015 reported subjective complaint of continued with right knee pain, popping, clicking and frequent falls. Previous treatment modality to include: activity modification, medications, therapy, injections, and surgical intervention. The following diagnoses were applied: internal derangement of the right knee, status post arthroscopy, 2014 lateral retinacular release and capsular imbrication: deep vein thrombosis, right; chronic pain and related sleep disturbance, weight loss, depression and sexual dysfunction.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 TENS unit with conductive garment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** The injured worker is a 49 year-old female patient who sustained an industrial injury on 11/30/2009. A primary treating office visit dated 07/20/2012 reported the patient with subjective complaint of right knee pain. She is status post right knee surgery on 08/06/2010. She is working and using the application of ice for comfort after work along with Alleve as needed. The following diagnoses were applied: knee strain. The plan of care involved discontinuing use of Naprosyn and prescribed Motrin and new knee sleeve. The patient is to go back to regular work duty 08/10/2012. A recent primary treating office visit dated 04/29/2015 reported subjective complaint of continued with right knee pain, popping, clicking and frequent falls. Previous treatment modality to include: activity modification, medications, therapy, injections, and surgical intervention. The following diagnoses were applied: internal derangement of the right knee, status post arthroscopy, 2014 lateral retinacular release and capsular imbrication: deep vein thrombosis, right; chronic pain and related sleep disturbance, weight loss, depression and sexual dysfunction.

**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/Functional Improvement Measures Page(s): 78-80/48.

**Decision rationale:** MTUS Guidelines have very specific criteria to justify the long term use of opioid medications. These criteria include a documented amount of pain relief, documentation of how long the pain relief lasts and clear documentation of functional gains as a result of use. These necessary outcomes are not reported in the medical records available for review. There is no documentation of meaningful pain relief specifically from opioid use and there is no documentation of functional support. Under these circumstances, the Norco #120 is not supported by Guidelines and is not medically necessary.