

Case Number:	CM13-0023336		
Date Assigned:	11/15/2013	Date of Injury:	04/06/2010
Decision Date:	01/29/2014	UR Denial Date:	09/04/2013
Priority:	Standard	Application Received:	09/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Oklahoma and 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 physician 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 patient is a 43-year-old male who reported an injury on 04/06/2010 after pulling a loaded dolly of beer towards his body causing a sharp pain in the left knee. An MRI was obtained, which revealed a medial meniscus tear. The patient underwent left knee arthroscopic surgery and was treated postoperatively with physical therapy. The patient had a repeat meniscus tear and underwent surgical intervention in 01/2011 and was provided postoperative physical therapy without significant benefit. The patient was provided with Synvisc injections. The patient underwent left knee partial replacement. The patient's chronic pain was managed with medications. The patient's most recent clinical examination findings included tenderness to palpation over the medial and lateral joint lines, parapatellar joint and medial bursa of the bilateral knees, bilateral knee joint effusion, and limited range of motion secondary to pain bilaterally. The patient's diagnoses included status post left knee sprain/strain and multiple left knee surgeries, residual left knee synovitis with swelling and weakness, status post right knee strain/sprain with right knee surgery, persistent right knee pain, and lumbar sprain/strain with bilateral radiculitis. The patient's treatment plan included continuation of medication and cognitive behavioral therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: The requested Percocet 10/325 #150 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has persistent and chronic pain complaints of the low back and bilateral knees. It is also noted that the patient has been on this medication for an extended duration of time. The California Medical Treatment and Utilization Schedule recommends that continuation of opioid usage in the management of a patient's chronic pain be supported by significant functional benefit, assessment of pain relief, management of side effects, and documented monitoring for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient has any functional benefit or significant pain relief as it is related to this medication. Additionally, there is no documentation that the patient is monitored for aberrant behavior. As such, the continued use of Percocet 10/325 mg #150 would not be medically necessary or appropriate.

Ambien 10mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Integrated Treatment/Disability Duration Guidelines, Stress & Mental Illness Chapter.

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

Decision rationale: The requested Ambien 10mg #20 is not medically necessary or appropriate. The Official Disability Guidelines recommend this medication for short-term use in the assistance of managing insomnia related to chronic pain. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. Additionally, the most recent documentation does not provide any evidence of functional benefit as it is related to prior usage of this medication. Therefore, continued use would not be indicated. As such, the requested Ambien 10mg #20 is not medically necessary or appropriate.