

<b>Case Number:</b>	CM14-0002307		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	01/24/2011
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	12/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 Occupational Medicine 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 patient is a female who was injured on 06/04/2010 and 01/24/2011. The mechanism of injury is unknown. Prior treatment history has included Norco, Soma, tramadol, and omeprazole; and a course of physical therapy. The patient underwent a total knee arthroplasty in 10/2012. Diagnostic studies reviewed include x-ray of the right knee dated 04/27/2013 demonstrates evidence of a total knee replacement. The prosthesis appears to be in good alignment and position. Medical re-evaluation note dated 04/27/2013 states the patient complains of pain in the right knee that is present on and off with medications. She ambulates with a cane and she walks with a limp. She states her symptoms radiates down the right leg to the right ankle/foot. She has numbness in the right foot and toes. She reports the right knee feels weak and unstable. On examination of the knees, ranges of motion exhibited extension to 10 on the right and 0 on the left; flexion to 110 on the right and 135 on the left. There is 2+ anterior laxity but no posterior laxity; and lateral stability test is normal. The patient is diagnosed with status post right knee surgery for a meniscectomy, internal derangement, tricompartmental osteoarthritis, Baker cyst, status post right knee arthroscopy; and status post total knee replacement surgery, right knee, with a foot-drop post-surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HYDROCODONE/APAP 10/325 MG #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids Page(s): 74-96.

**Decision rationale:** MTUS guidelines recommend opioids for moderate to severe chronic pain if functional benefit and pain reduction are established. The patient appears to be taking this medication on a chronic basis. However, the only clinical note provided for review is an AME dated 4/30/13. There are no medical records provided that document functional benefit or pain reduction attributable to use of this medication. Medical necessity is not established.