

Case Number:	CM14-0009880		
Date Assigned:	02/21/2014	Date of Injury:	04/09/2009
Decision Date:	06/25/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	01/27/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California and Nevada. 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 65 year old male who is reported to have sustained work related injuries on 04/09/09. The records indicate that on the date of injury, the injured worker was carrying 2 x 4s on a job site. He squatted down and twisted to the left with the knees and felt sharp pain in the left knee. He subsequently underwent a left knee arthroscopy on 04/30/09. He later underwent a left total knee arthroplasty on 08/17/11. Most recently, he has undergone a revision of the left total knee arthroplasty on 01/22/13. Postoperatively, the injured worker had chronic left knee pain. He has been treated with oral medications, physical therapy, and aquatic therapy. Current medications include Norco, Nabumetone, and Pennsaid drops. The record contains a utilization review determination dated 01/15/14 which requests for Hydrocodone/Acetaminophen 10/325mg #60, Hydrocodone/Acetaminophen 10/325mg #90, and Pennsaid 1.5% solution, 40 drops, were not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE-ACETAMINOPHEN 10-325 MG 1 TWICE DAILY AS NEEDED # 60:
Overturned

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, , PAGE 91

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Opiates, Page(s): 74-80.

Decision rationale: The request for Hydrocodone/Acetaminophen 10/325mg, #60 is recommended as medically necessary. The submitted clinical records indicate that the injured worker is status post left total knee arthroplasty revision performed on 01/22/13. Postoperatively, the injured worker is noted to have chronic pain which is relieved significantly by the use of this medication 2 times daily. Records indicate that the continued use of Norco 10/325 allows the injured worker to have significant functional improvements. The record includes urine compliance testing which indicates there is no diversion and that the injured worker is taking his medications appropriately. As such, the injured worker would meet criteria for the continued use of this narcotic medication.

HYDROCODONE-ACETAMINOPHEN 10-325 MG THRICE DAILY AS NEEDED # 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, , PAGE 91

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Opiates Page(s): 74-80.

Decision rationale: The request for Hydrocodone/Acetaminophen 10/325mg, three times a day as needed, #90 is not supported as medically necessary. This represents a redundant request. Serial clinical notes from the requestor indicate the injured worker has adequate pain management with two pills per day. There is no rationale provided for this 2nd prescription or the need to increase to three times per day. As such, the request would not meet CA MTUS guidelines and is therefore found to be not medically necessary.

PENNSAID 1.5 PERCENT SOLUTION 40 DROPS TO AFFECTED KNEE 2-3 TIMES PER DAY AS NEEDED #2: 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, , PAGE 111-112

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Topical Analgesics, Page(s): 112-113.

Decision rationale: The request for Pennsaid 1.5% solution, 40 drops to the affected knee, 2-3 times per day is not supported as medically necessary. Per CA MTUS, the efficacy of topical analgesics has not been established through rigorous clinical trials. The record indicates the injured worker has subjective reports of improvement with the use of this topical application which is not quantified. This data is insufficient to overcome the lack of peer reviewed literature to establish benefit.

