

Case Number:	CM14-0012653		
Date Assigned:	02/21/2014	Date of Injury:	05/18/2012
Decision Date:	07/23/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	01/31/2014

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 Tennessee. 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 60-year-old male who has submitted a claim for status post left knee patellofemoral arthroplasty associated with an industrial injury date of May 18, 2012. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of persistent severe left knee pain. Physical examination revealed 2.5cm atrophy of quadriceps above the left patella. Twitching and shaky muscle response to passive range of motion of both legs was noted. There was an active extensor lag. Left patellar reflex was diminished due to pain. There was small cold effusion and mild tenderness along the infrapatellar tendon. Treatment to date has included a knee brace, aquatic therapy, physical therapy, partial left patellofemoral replacement surgery 10/15/12, cortisone injection, and medications, which include Norco, Ambien, Toradol injection and Percocet. Utilization review from January 15, 2014 modified the request for Percocet 10/325mg #120 to Percocet 10/325mg #30 because there was no objective evidence of functional improvement with prior use of Percocet. Also, there was no documentation that the patient signed an agreement and contract for use of chronic opioid therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCOCET 10/325 #120 -1-2 TABLETS EVERY 4-6 HOUYRS AS NEEDED: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS FOR CHRONIC PAIN Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On- going Management Page(s): 78-81.

Decision rationale: According to pages 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, ongoing opioid treatment is not supported unless prescribed at the lowest possible dose and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The monitoring of these outcomes over time should affect therapeutic decision and provide a framework for documentation of the clinical use of these controlled drugs. In this case, records indicate that the patient has been on Percocet since 5/16/13 although the exact date of initiation is not known. Specific measures of analgesia and functional improvements, such as improvements in activities of daily living were not documented. There was also no documentation of adverse effects or aberrant behaviors. No toxicology screenings are available. Additional information is needed as guidelines require clear and concise documentation for ongoing management. Medical necessity has not been established. Therefore, the request for Percocet 10/325 #120 1-2 tablets every 4-6 hours as needed is not medically necessary.