

Case Number:	CM14-0152763		
Date Assigned:	09/22/2014	Date of Injury:	10/28/1983
Decision Date:	10/21/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/15/2014

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:

According to the provided documents, this is a 61-year-old gentleman with an injury that occurred on 10/28/83. The mechanism of injury was not found in the documents. The patient has had bilateral knee replacements. The disputed requests being addressed are oxycodone hydrochloride 15 mg one every 8 hours PRN and consultation for 2nd surgical opinion in a utilization review determination letter from 8/22/14. There is an 8/22/14 utilization review decision that indicates that the same reviewer had approved a request for oxycodone hydrochloride 15 mg #180 on 8/11/14. The document also indicates that the prescribing physician was not aware of the August 11 certification according to a phone call with a staff member on 8/22/14. There is an 8/19/14 non-weight bearing x-ray of the bilateral knees, it states that the bilateral knee replacements are seen without evidence of hardware loosening and the impression was unremarkable bilateral knees. There is a laboratory report from 8/21/14 that includes a complete blood count entirely within normal limits and a manual sedimentation rate of 3 which was also within the normal range of 0-20 mm/h. C-reactive protein with 0.6, normal being less than 0.8. A physical medicine and rehabilitation report from 7/29/14 includes subjective complaints of increased knee and back pain, constant 9/10. There is weakness and swelling. Medication is reportedly 60% helpful and effective, gives patient some relief and allows him to at least tolerate less than normal activities throughout the day. There is no mention made of the actual daily quantity of oxycodone used on average. The activities of daily living section say that in terms of pain, cooking and lower extremity dressing have been problematic along with sexual activity. Objective findings included moderate effusion of the knees, no crepitation, moderate laxity varus and valgus stress bilaterally, and 1+ pitting edema. Range of motion of right knee +20 extension, +10 on the left, flexion 80 bilaterally. There is reduced strength with knee extension and flexion. Diagnoses were pes anserine bursitis, abnormality of

gait, localized osteoarthritis not otherwise specified of the lower leg. Surgical opinion referral was requested along with bilateral knee braces. The patient's current medications would be continued. A 7/3/14 physiatrist report indicated that the patient reported symptoms have gotten worse since last visit. A 6/3/14 physiatrist report included subjective complaints of worsening pain and more difficulty sleeping. The assessment notes persistent progressive weakness in the quad muscles. There is note of increasing difficulty with ADLs. No other reports mention any patient participation in a home exercise program, although one report asked for a gym membership. There is no mention of any consideration for physical therapy for the progressive symptoms. Not available for the original review, a physiatry report from 9/2/14 also documents ongoing worsening symptoms and difficulty with ADLs. This report did recommend physical therapy. The earliest available report that mentioned prescription of the oxycodone was 5/1/14 which indicated that it was a current medication implying use prior to that date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone HCL 15mg, 1 q8hrs PRN: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 74-75, 78-79, 92.

Decision rationale: This is a short acting opiate medication. Use of this medication has been since sometime before May 2014, thus use is chronic. Ongoing management of opiates per MTUS guidelines should include the lowest possible dose to improve pain and function. There is no mention of the actual daily frequency of use of the medication. Despite ongoing use, the reports document progressive worsening of the patient's pain and decrease in activities of daily living. MTUS guidelines state that opiates should be discontinued when there is no overall improvement in function. Thus, taking into consideration the evidence and the guidelines the continued use of the Norco is not medically necessary.

Consultation for surgical second opinion: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 343-344.

Decision rationale: At the time this was requested, the patient was having progressive worsening pain in the knees with no specific documentation of any precipitating events or increase in activity. The request comes from the psychiatrist, not orthopedic surgery, and at the time the request was made there had been no specific diagnostic testing done to try to determine a source for the pain and no conservative treatment provided for the flare-up of pain such as physical therapy. ACOEM guidelines indicate that for the knee, surgical consultations are indicated when there has been a failure of exercise programs to increase range of motion and strengthen the musculature about the knee, and that in the absence of red flags work-related knee complaints can be managed safely and effectively by occupational or primary care providers. At the time of the request, there had been no identification of any red flags such as possible infection of the prosthesis or loosening of the prosthesis, there had been notation of progressive weakening of the musculature but no mention of any instruction in a home exercise program or referral for physical therapy. This request is not medically necessary.