

Case Number:	CM14-0074353		
Date Assigned:	07/16/2014	Date of Injury:	07/16/2010
Decision Date:	09/24/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/21/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Louisiana. 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 42 year old female who sustained an injury on 07/13/2010. The mechanism of injury is unknown. Progress report dated 02/08/2014 states the patient presented with left knee pain rated as 9/10 without medications and 8-9/10 with medications. Progress report dated 04/24/2014 states the patient presented with arthrofibrosis of the left knee. She has received Supartz injections and has had a severe reaction that has resulted in her inability to bend her knee and walks with the aid of a cane. On exam, she has painful range of motion of her ankle. She has residual disability with almost complete loss of function of her left lower extremity. Prior utilization review dated 05/16/2014 states the requests for Percocet 10/325 mg #60; and Terocin 4 oz bottle are denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 105, 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Opioids.

Decision rationale: According to the MTUS Chronic Pain Guidelines, Opioids are recommended as the standard of care for treatment of moderate to severe pain for short term use. There are no supporting documentation showing any sustainable improvement in pain or function, and long term use of opiates is not supported by current evidence based guidelines. The request for this medication is not medically necessary.

Terocin 4 oz bottle: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: According to the MTUS Chronic Pain Guidelines, Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Recommended for short-term use for (4-12weeks) and there are no long-term studies of their effectiveness or safety. In this case, there is no progression or documented functional improvement, and has exceeded the guidelines for the recommended time use. This medication is not medically necessary.