

Case Number:	CM14-0205366		
Date Assigned:	12/17/2014	Date of Injury:	08/01/2013
Decision Date:	02/10/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/08/2014

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 Family Practice 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:

This 45-year old chef reported a right knee injury after falling of a loading dock on 8/1/13. Previous treatment included an arthroscopic debridement and chondroplasty performed in 2/14. Postoperative treatment included Percocet and physical therapy. A follow-up note dated 4/10/14 documented that he was no longer taking Percocet, and was taking ibuprofen. He continued to have pain and had not returned to work. On 5/22/14, his provider documented that he would be submitting a request for ACI (autologous chondrocyte implantation) of the medical femoral condyle and HTO (high tibial osteotomy). At that point the patient was taking no medications and was still off work. The surgery was authorized on 6/3/14 and was to be performed on 1/28/14. According to the UR report of 11/24/14, the treating physician saw the patient on 11/24/14 for a steroid injection of his knee. The physician noted that the patient was taking two Percocet per day, which was the same dose and frequency as of a request for authorization dated 8/1/14. Neither the 11/24/14 note nor the 8/1/14 RFA is present in the records available to me. The records also do not contain any notes that make it clear when the patient resumed Percocet use. The request for Percocet 10/325 #60 was non-certified in the UR of 11/24/14 on the basis of lack of information regarding the patient's opioid history, lack of appropriate documentation for opioid use, and because short-acting opioids are not indicated for chronic pain. ACOEM 2014: Opioids was cited. On 12/31/14, the provider wrote a letter of appeal regarding this decision. It states that the patient has been authorized for a procedure that includes cartilage replacement and possible osteotomy. He will need some type of short-acting narcotic for postoperative pain management. The provider states that it is imperative that the patient get pre-authorization so that he has such narcotic pain medication to use as needed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2014: Opioids

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, an online, evidence-based review service for clinicians (www.uptodate.com), Management of postoperative pain

Decision rationale: According to UptoDate reference cited above, pain medication following ambulatory surgery under sedation should include intravenous fentanyl, followed by oral pain relievers. These may include Codeine, Oxycodone, or combinations of Codeine or Oxycodone with Acetaminophen or Aspirin. Depending upon the severity of the pain, prior allergies, prior patient experience and tolerance of these medications, any of these oral medications can be prescribed and tailored to the needs of the individual. The clinical documentation in this case supports the provision of a short course of Percocet to this patient. He has been authorized for a knee surgery that is likely to cause significant postoperative pain. He had a previous surgery on the same knee and received Percocet for his postoperative pain. He was off Percocet by two months later. Although it appears that he subsequently resumed Percocet in 8/14, this would not be a reason for denying him medication for acute postoperative pain. Even though the patient's provider does not appear to have performed the appropriate evaluation and documentation for chronic opioid use, it is not appropriate to address this issue at the point where the patient is about to undergo a surgery which is likely to cause significant acute pain. Based on the evidence-based citation above and on the clinical documentation provided for my review, Percocet 10/325 #60 is medically necessary, because the patient is about to undergo a surgery which is likely to cause significant pain, and because the patient has used postoperative Percocet with success in the past.