

<b>Case Number:</b>	CM15-0043577		
<b>Date Assigned:</b>	03/13/2015	<b>Date of Injury:</b>	05/07/2012
<b>Decision Date:</b>	04/16/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 53-year-old male who sustained an industrial injury on 5/07/12. The mechanism of injury was not documented. He underwent left knee arthroscopy with partial meniscectomy in August 2013, followed by 24 post-op physical therapy visits. The 8/25/14, 10/20/14, and 12/1/14 progress reports documented the on-going use of hydrocodone with no documentation of associated reduction in pain, increase in functional ability, or improvement in quality of life. The 1/26/15 treating physician report cited complaints of left knee pain, low back pain radiating to the right lower extremity, and cervical pain with left greater than right upper extremity symptoms. Left knee exam documented global tenderness, swelling, and crepitus with range of motion. Lumbar spine exam documented diffuse tenderness, decreased range of motion, and positive right straight leg raise. Cervical exam documented diminished range of motion, and unchanged upper extremity neurologic exam. The diagnosis was cervical myofascial pain, status post left knee surgery, and L5/S1 disc protrusion. The treatment plan recommended additional physical therapy to the left knee 3x4, hydrocodone 7.5 mg twice daily, pantoprazole 20 mg twice daily, cyclobenzaprine 7.5 mg three times daily, and naproxen 550 mg twice daily. The 3/5/15 utilization review non-certified the request for additional post-op physical therapy as there was no rationale to support additional physical therapy in excess of guidelines, or over a self-directed home exercise program. The request for hydrocodone/APAP 7.5 mg/325 mg #60 was non-certified as there were no objective findings to support the medical necessity of this medication and no evidence of benefit or demonstrated functional improvement with use.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 7.5 mg, sixty count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80 - 82.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): 76-80, 91.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines support the use of hydrocodone/acetaminophen (Vicodin) for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. On-going management requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Guideline criteria have not been met for on-going use of this medication in the absence of guideline required documentation. There is no documentation of reduced pain, increased function, or improved quality of life relative to medication use in the progress reports since 8/25/14. The 3/5/15 utilization review recommended tapering down and off this medication. There is no documentation of on-going opioid therapy management relative to pain reduction and functional assessment. Therefore, this request is not medically necessary.

**Post-operative physical therapy for the left knee, three times weekly for four weeks:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337 - 339. Decision based on Non-MTUS Citation ACOEM updated guidelines, Back Chapter, 2007, and third edition, pages 111 - 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, Physical Medicine Page(s): 9, 98-99, Postsurgical Treatment Guidelines Page(s): 24.

**Decision rationale:** The California MTUS Post-Surgical Treatment Guidelines do not apply to this case as the 6-month post-surgical treatment period had expired. MTUS Chronic Pain Medical Treatment Guidelines would apply. The MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. Guidelines generally support up to 10 visits for chronic pain and myalgia/myositis. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. Guideline criteria have not been met. This injured worker completed an extensive course of post-op treatment. There are no current specific objective functional deficits or a functional treatment goal documented to be addressed by additional supervised physical therapy. There is no compelling reason to support the medical

necessity of additional supervised therapy over an independent home exercise program.  
Therefore, this request is not medically necessary.