

Case Number:	CM15-0086482		
Date Assigned:	05/08/2015	Date of Injury:	05/26/2014
Decision Date:	06/09/2015	UR Denial Date:	04/01/2015
Priority:	Standard	Application Received:	05/05/2015

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 34 year old male, who sustained an industrial injury on 05/26/2014. He reported injuring his left knee after a fall at work. The injured worker is currently not working. The injured worker is currently diagnosed as having left knee sprain/strain with medial meniscal tear, status post left knee arthroscopy, persistent left knee bursitis and osteoarthritis, altered gait due to chronic left knee pain, and chronic pain syndrome. Treatment and diagnostics to date has included left knee MRI on 10/22/2014, left knee surgery, physical therapy, cortisone injections, home exercise program, and medications. In a progress note dated 03/02/2015, the injured worker presented with complaints of left knee pain. Objective findings include tenderness, swelling, and effusion in the left knee. The treating physician reported requesting authorization for Percocet, ice compression wrap, and left knee MRI.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80, 83.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 74-96.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function. Consideration of other pain treatment modalities and adjuvants is also recommended. Given the lack of evidence of functional improvement while chronically taking Percocet, in light of the chronic nature of this case, the decision to wean per utilization review is reasonable, and therefore the request for Percocet is not medically necessary.

Ice compression wrap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cold/Heat Packs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, cryotherapy.

Decision rationale: The Official Disability Guidelines discuss the use of continuous-flow cryotherapy in cases of post-operative knee treatment. The use of these devices is recommended for up to seven days, including home use. Continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. Given the provided records indicating that the patient is not in an immediate post-operative period, the requested modality does not meet the standard set by the guidelines. Therefore, based on the guidelines and provided documents, the request for cryotherapy treatment is not medically necessary.

MRI of the left knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), MRI of knee.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 342-343.

Decision rationale: Per the cited ACOEM guideline, special studies are not needed to evaluate most knee complaints, until after a period of conservative care and observation. However, if there is a history of trauma with red flags, such as inability to walk four steps, or inability to flex knee to 90 degrees. Based on the available medical records for the injured worker (IW), there are no red flags, and recent notes mention effusion, but no objective measures of range of motion or

tests for instability, etc., are mentioned. Therefore, a period of conservative management with physical medicine, etc. is a reasonable option prior to proceeding with an MRI and consideration of further surgery. As a result the request is not medically necessary.