

Case Number:	CM15-0111761		
Date Assigned:	06/18/2015	Date of Injury:	03/09/2011
Decision Date:	07/27/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/09/2015

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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

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 50-year-old male, who sustained an industrial injury on 03/09/2011. The injured worker complained of left knee injury. On a provider visit dated 04/29/2015 the injured worker had reported left knee pain. On examination of the left knee, there were objective findings of a positive patellar grind maneuver, hamstring tenderness and tenderness in the medial and lateral aspect as the knee. There was a well-healed arthroscopic portals as well as a vertical anterior incision. A decreased range of motion was noted. The diagnoses have included left knee pain status post femoral osteochondral allograft - 03/26/2014, right knee strain - compensatory and stress syndrome. Treatment to date has included physical therapy and medications noted as Norco, Percocet, Oxycontin, Oxycodone, Colace and Hydrocodone. The injured worker was noted as not currently working. There was no clear evidence of any significant reduction in pain level or improvement in functional capacity noted. The provider requested Norco 10/325 mg Qty 60, 1 by mouth 2 times daily as needed for breakthrough pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg Qty 60, 1 by mouth 2 times daily as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 91, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 42-43, 74-96, 124. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

Decision rationale: The CA MTUS and the ODG guidelines recommend that opioids can be utilized for the treatment of exacerbation of musculoskeletal pain when standard treatment with NSAIDs and PT has failed. The chronic use of opioids can be associated with the development of tolerance, dependency, addiction, sedation and adverse interaction with other medications. The records did not show that the patient failed treatment with NSAIDs and non-opioid co-analgesic. The patient was noted to be utilizing multiple short acting and an extended release opioid medication concurrently. There is no documentation of guidelines mandated compliance monitoring with serial UDS, CURES data reports, functional restoration and absence of aberrant behavior or adverse effects. The criteria for the use of Norco 10/325mg #60 were not medically necessary.