MAXIMUS Federal Services

| Case Number: | CM15-0176445 | | |
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| Date Assigned: | 09/17/2015 | Date of Injury: | 08/30/1999 |
| Decision Date: | 10/21/2015 | UR Denial Date: | 08/19/2015 |
| Priority: | Standard | Application Received: | 09/08/2015 |

## 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: California
Certification(s)/Specialty: Emergency 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 59 year old male, who sustained an industrial injury on 8-30-1999. The injured worker was diagnosed as having pain in joint, lower leg. His medical history included diabetes, depression, liver disease, and anxiety. Treatment to date has included diagnostics, physical therapy, multiple right knee surgeries (most recently right total knee replacement in 7-2014 and exploration right total knee arthroplasty, excision of scar tissue and lateral release, with medial imbrication extensor mechanism on 5-21-2015), cold therapy, Synvisc injections, mental health, and medications. Percocet 10-325mg (2 tablets three times daily) was prescribed per the progress report 2-19-2015, noting prior use of Norco. His pain level on 2-19-2015 was documented as 8 out of 10, noting Norco use reduced his pain to 6-7 out of 10 from 8-9 out of 10. The increased pain level was attributed to cold weather and intensive physical therapy, noting the use of a cold therapy unit. His pain level was 7 out of 10 on 3-05-2015 and 8 out of 10 on 4-17-2015 and 5-18-2015. The progress report (6-11-2015) noted pain level at 9 out of 10, noting the use of Percocet 10+ per day and being given Norco 10-325mg #50 post-operatively. On 6-11-2015, he reported the need for the continued use of cold unit and CPM (continuous passive motion) machine. Fentanyl 25mcg was prescribed per the visit on 7-13-2015. Currently 8-10-2015), the injured worker complains of pain level 8 out of 10 with the use of Fentanyl 25mcg and Percocet (max 4 per day). He reported continued benefit with cold therapy unit and requested purchase. Physical exam noted a slow and antalgic gait with [redacted] crutch. Exam of the right knee noted "decreased" range of motion but able to extend and bend somewhat, tenderness throughout, and steri strips over "very swollen deformed" right knee, with

dislocation, and numbness laterally. The treatment plan included Percocet 10-325mg #120, Fentanyl patch 25mcg #10, and a cold therapy unit for indefinite use. This was modified by Utilization Review on 8-19-2015 to Percocet 10-325mg #90 and Fentanyl patch 25mcg #8.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, long-term assessment.

**Decision rationale:** Percocet is acetaminophen and oxycodone, an opioid. Patient has chronically been on an opioid pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails to show any benefit from current opioid therapy. There is minimal improvement in pain and no documented improvement in functional status. There is no documented long term plan concerning the use of opioids. Documentation fails to support current opioid therapy with no efficacy or long term plan noted. Percocet is not medically necessary.

**Fentanyl patch 25mcg #10:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Fentanyl, Opioids, criteria for use, Opioids for chronic pain, Opioids, long-term assessment.

**Decision rationale:** Fentanyl is an extremely potent opioid. Patient has chronically been on an opioid pain medication. It is not recommended as a 1st line medication and is only recommended for patients whose pain cannot be controlled using other methods. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails to show any benefit from current opioid therapy. There is minimal improvement in pain and no documented improvement in functional status. There is no documented long term plan concerning the use of opioids. Documentation fails to support current opioid therapy with no efficacy or long term plan noted. Fentanyl is not medically necessary.

**Cold therapy unit (indefinite use):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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/ Leg: Continuous-flow cryotherapy.

**Decision rationale:** MTUS Chronic pain and ACOEM Guidelines do not have any sections that relate to this topic. As per Official Disability Guidelines, continuous cold units are only recommended for 7days post operatively. There is no utility in long term use. Patient has completed use of cold therapy with subjective claims of improvement. Patient is requesting it because he thinks it will be helpful. There is no evidence to support use of this device for reason given. Cold therapy unit is not medically necessary.