

<b>Case Number:</b>	CM13-0046144		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	12/19/1996
<b>Decision Date:</b>	04/25/2014	<b>UR Denial Date:</b>	11/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2013

### 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 Internal Medicine 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:

The patient is a 60 year old male who sustained a workplace injury on 12/19/1996. The mechanism of injury was not found in records reviewed. Prior treatment history has included water therapy and medications including oxycodone 30 mg, percocet 10/325 mg, OxyIR 30 mg, Ativan 2 mg, and Exalgo 16 mg. The patient has had 14 total surgeries with the most recent surgery a right hip replacement in 2011. A clinic note dated 12/09/2013 documented the patient to have significant problems with his low back, his left knee, and left hip. The patient has been unable to go to pool therapy because where he has gone before has been in [REDACTED]. The patient said in the water, his pain is much diminished and he can exercise. Otherwise, his pain is about a 10/10, coming down to 8/10 with his medication. Objective findings on exam showed that the left leg has very weak quadriceps. The patient has a significantly decreased range of motion of the left knee and hip. He also has pain with movement. The patient was diagnosed with chronic pain syndrome with chronic low back pain; bilateral hip joint pains, history of right hip replacement on 2011; and chronic bilateral knee pains with left knee replacement on 2009.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxy IR 30mg, QTY 360:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-80 and 86-87.

**Decision rationale:** The guidelines state that if there is no overall improvement in function, opioids should be discontinued. The medical records do not establish that this patient has obtained overall improvement in function or has returned to work. The patient describes only a minimal reduction in pain level, despite significant opioid usage. This patient's Oxy IR dosage exceeds the maximum daily allowed amount, per the guidelines. Therefore, the requested Oxy IR is not medically necessary or appropriate.

**Percocet 10/325mg, QTY 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-80, 86-87, and 91.

**Decision rationale:** The patient reports his pain is 10/10, and decreases to 8/10 with his medications. The medical records demonstrate the patient has not obtained a clinically significant reduction in pain. He also has not had increased function as result of opioid medication usage. Therefore, the requested Percocet is not medically necessary or appropriate.

**Ativan 2mg, QTY:120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24 and 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Lorazepam

**Decision rationale:** According to the evidence-based guidelines, lorazepam (Ativan) is not recommended for use. With benzodiazepines, there is risk of dependence, addiction, and it is a major cause of overdose. In this case, the patient does not present with any subjective complaints or objective findings of anxiety. The medical records do not provide a viable rationale as to establish this prescription of a medication that is not recommended under the evidence-based guidelines. Therefore, the medical necessity of Ativan is not established.

**Exalgo 16mg, QTY:30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-81.

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

**Decision rationale:** The Official Disability Guidelines state that Exalgo is an extended release opioid recommended for the management of moderate to severe pain for patients requiring around-the-clock analgesia for an extended period of time. In this case, the patient has not demonstrated adequate relief with ongoing opioid therapy, despite high doses. He has not shown adequate increase in functionality to justify ongoing high dose opioid therapy. Therefore, the requested Exalgo is not medically necessary or appropriate.