

Case Number:	CM14-0101977		
Date Assigned:	09/16/2014	Date of Injury:	12/05/1998
Decision Date:	10/24/2014	UR Denial Date:	06/18/2014
Priority:	Standard	Application Received:	07/02/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 59-year-old female with an injury date of 12/05/1998. Based on the 06/03/2014 progress report, the patient uses a wheelchair and complains of hip and knee pain. With medications, the patient rates her pain as a 1/10 and without medications; she rates her pain as a 10/10. She has a painful and antalgic gait. The patient has tender lumbar paraspinal muscles, painful tenderness over midline and paraspinal areas, tender and marked tenderness over facet joints, hip flexion is poor, pain with flexion, abduction, and external rotation, pain with internal and external rotation, pain to palpation posterior hip and left trochanter tenderness, tender left paralumbar, and tender right paralumbar. In regards to the left upper extremity, the patient has pain with flexion and decreased extension. In terms of the right lower extremity, the patient has radiation of pain, tenderness to palpation, decreased flexion, pain with flexion, decreased extension, decreased pronation, pain with pronation, decreased supination, and pain with supination. The patient's diagnoses include lumbago, low back pain, knee pain/joint pain leg, osteoarthritis, ENCINTR long-Rx use, shoulder region disk, hip/pelvic PN, leg pain, sacroiliac joint dysfunction, myofascial pain syndrome/myalgia, radiculitis, lumbar and thoracic, disk degeneration, lumbo/sacral and pain, shoulder joint. The utilization review determination being challenged is dated 06/18/2014. Treatment reports were provided from 01/14/2014 - 08/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 30mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain Page(s): 60, 61.

Decision rationale: According to the 06/03/2014 progress report, the patient complains of having hip pain and knee pain. The request is for oxycodone 30 mg #30. The patient has been taking oxycodone as early as 01/14/2014. The 01/14/2014 progress report indicates the patient was taking oxycodone 15 mg at the time. The 06/03/2014 progress report indicates that the physician would like to up the patient's dosage of oxycodone from 15 mg to 30 mg. The patient is noted to have a pain scale of 1 out of 10 with medications and a 10/10 without medications. The 05/06/2014 report indicates that the patient "is able to dress herself but with help. She has limitation on dressing due to pain and inability to stand without support and unable to do any housework. She states she spends most of her day in bed." MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain management" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. In this case, pain scales were provided. However, there was no mention of any adverse side effects/behavior. The patient does not seem to be improving with her activities of daily living either. Therefore the request is not medically necessary.

Oxycontin 80mg #130: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60, 61.

Decision rationale: Based on the 06/03/2014 progress report, the patient complains of having hip pain and knee pain. The request is for OxyContin 30 mg #130. The patient has been taking OxyContin 80 mg as early as 01/14/2014. The 06/03/2014 report indicates that the patient rates her pain as a 1/10 with medications and a 10/10 without medications. The 05/06/2014 progress report indicates that the patient "is able to dress herself but with help. She has limitation on dressing due to pain and inability to stand without support and unable to do any housework. She states she spends most of her day in bed." MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. In this case, the physician has provided a pain scale; however, it does not provide any adverse side

effects/behavior discussions. The patient does not seem to be improving her activities of daily living with her medications. Therefore the request is not medically necessary.

Valium 5mg #45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Based on the 06/03/2014 progress report, the patient complains of having hip pain and knee pain. The request is for Valium 5 mg #45. The patient has been taking Valium as early as 03/14/2014. MTUS page 24 states that benzodiazepines are "not recommended for long-term use because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks." In this case, the patient has been taking Valium since 03/14/2014 which exceeds the 4 weeks recommended by MTUS Guidelines. Therefore the request is not medically necessary.