

<b>Case Number:</b>	CM14-0170801		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	11/16/1978
<b>Decision Date:</b>	01/20/2015	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2014

### 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 and 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 71 year old male with an injury date of 11/16/78. Per the 09/25/14 Progress report the patient presents with improved chronic left shoulder pain along with chronic neck and lower back pain. Pain without medications is 10/10 and with is 6/10 and radiates over the entire body. The patient also presents with sleep difficulties as some medication has not been authorized. The patient is post above right knee amputation and ambulates with a motorized scooter. He is retired. Examination of the shoulders reveals reduced range of motion due to pain. There is diffuse tenderness to palpation of the right shoulder. Further examination shows mild to moderate spasm along the right lateral border between T2-3 along with tenderness with light palpation. All lumbar motion elicits pain with tenderness to palpation of: lateral hip, severe; entire left shoulder, moderate; posterior neck; and lumbosacral spine. Neurological examination shows burning, tingling, sharp phantom pain in the right leg at amputation. The patient's diagnoses include: 1. Right hip/buttock pain over AKA stump 2. Chronic lower back pain, currently not well controlled due to lack of pain medication 3. Degenerative T12-S1 disc 4. L3-4 and L4-5 spinal stenosis 5. S/p right AKA 20006. Bilateral shoulder pain 7. Diffuse body pain 8. Sacroiliac pain made worse by all prolonged positions 9. Left shoulder degenerative joint disease 10. Chronic pain syndrome 11. Insufficient pain coverage via medications Current medications include: Vicodin, Lorazepam, Dilaudid, HCTZ, DSS, Gabapentin, Aspirin, Oxycodone, Docusate, Omeprazole and Benazepril. The utilization review being challenged is dated 10/01/14. The rationale regarding transfer sessions x 2 is that there is insufficient clinical evidence to support the request. Reports were provided from 02/03/14 to 10/24/14.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Sessions with instructor times two (2) (transfers): Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The patient presents with chronic left shoulder pain along with chronic neck and lower back pain, diffuse pain throughout the body and sleep difficulties. There is also burning, tingling, phantom pain in the right leg. The patient is status post right above the knee amputation in 2000. The treating physician requests for Sessions With Instructor Times Two (2) (Transfers per report of unknown date. The 10/01/14 utilization review states the request was received 09/25/14. The RFA is not included. MTUS pages 98, 99 states that for Myalgia and myositis 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis and radiculitis 8-10 visits are recommended. The treating physician does not discuss this request in the reports provided. The 09/25/14 report states that movement from the wheelchair to the examination table is prevented by pain. The treating physician also states regarding the patient's ADL's that he cannot do anything. The utilization review states that that on 09/30/14 a call was made to the treating physician, [REDACTED], and it was confirmed that this request is for physical therapy X 2 to allow transfer from a wheelchair. The 02/03/14 report states that physical therapy X 2 is requested to evaluate the patient's needs. On 04/24/14 the treating physician again requests for 2 sessions to evaluate the patient and future DME needs. The reports do not show if the patient received this therapy and no physical therapy reports are provided. There is no evidence the patient has received recent physical therapy or that the patient is within a post-surgical treatment period. In this case, the reports show the patient ambulates with a power wheelchair, has restricted ADLs and difficulty transferring from the wheelchair due to pain. It appears the patient may benefit from the requested two sessions that are within what is allowed by MTUS. The request IS medically necessary.

### **Vicodin ES 7.5-300mg, #150: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Criteria For Use Of Opioids Page(s): 60, 61 88,89 76-78.

**Decision rationale:** The patient presents with chronic left shoulder pain along with chronic neck and lower back pain, diffuse pain throughout the body and sleep difficulties. There is also burning, tingling phantom pain in the right leg. The patient is status post right above the knee amputation in 2000. The treating physician requests for Vicodin ES 7.5-300 mg #150 (Hydrocodone an opioid) per unknown date. The 10/01/14 utilization review states the request

was received 09/25/14. The RFA is not included. Utilization review modified this request from #150 to #120. 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. The reports show the patient has been prescribe opioids (Percocet/Oxycodone) since at least 02/03/14. The 08/26/14 report notes Percocet was stopped following 1 week hospitalization for duodenal ulcer. Hydrocodone has been prescribed since at least 06/25/14. In this case pain is routinely assessed through the use of pain scales. Pain is rated 7/10 on 04/24/14, 8/10 on 06/25/14 and 6/10 with medications and 10/10 without on 09/25/14. The treating physician notes that pain is not adequately controlled as some pain medications have not been authorized. On 09/25/14 the treating physician states regarding the patient's ADL's, "This patient reports that he cannot do anything." However, no specific ADL's are mentioned to show a significant change with use of this medication. Opiate management issues are not fully addressed. No Urine Toxicology reports are provided or discussed. There is no mention of CURES. Side effects are only partially discussed when the treating physician notes that Percocet is discontinued. No outcome measures are provided. In this case, it does not appear that there is sufficient documentation to support long-term opioid use as required by MTUS. The request IS NOT medically necessary.

#### **Hydromorphone HCL 2mg, #40: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Criteria For Use Of Opioids Page(s): 60,61, 88, 89, 76-78.

**Decision rationale:** The patient presents with chronic left shoulder pain along with chronic neck and lower back pain, diffuse pain throughout the body and sleep difficulties. There is also burning, tingling phantom pain in the right leg. The patient is status post right above the knee amputation in 2000. The treating physician requests for Hydromorphone HCL 2 mg #40 (an opioid) per unknown date. The 10/01/14 utilization review states the request was received 09/25/14. The RFA is not included. 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. The reports show the patient has been prescribe opioids (Percocet/Oxycodone) since at least 02/03/14. The 08/26/14 report notes Percocet was stopped following 1 week hospitalization for duodenal ulcer. Hydrocodone has been prescribed since at least 06/25/14. This medication (Dilaudid) shows as refilled on 09/25/14. It is unclear from the reports provided when this medication was started. In this case, pain is routinely assessed through the use of pain scales. Pain is rated 7/10 on 04/24/14, 8/10 on 06/25/14 and 6/10 with medications and 10/10 without on 09/25/14. The

treating physician notes that pain is not adequately controlled as some pain medications have not been authorized. On 09/25/14 the treating physician states regarding the patient's ADL's, "This patient reports that he cannot do anything." However, no specific ADL's are mentioned to show a significant change with use of this medication. Opiate management issues are not fully addressed. No Urine Toxicology reports are provided or discussed. There is no mention of CURES. Side effects are only partially discussed when the treating physician notes that Percocet is discontinued. No outcome measures are provided. In this case, it does not appear that there is sufficient documentation to support long-term opioid use as required by MTUS. The request IS NOT medically necessary.

**Lorazepam 1mg, #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

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

**Decision rationale:** The patient presents with chronic left shoulder pain along with chronic neck and lower back pain, diffuse pain throughout the body and sleep difficulties. There is also burning, tingling, phantom pain in the right leg. The patient is status post right above the knee amputation in 2000. The treating physician requests for Lorazepam 1 mg #30 (a Benzodiazepine) per unknown date. The 10/01/14 utilization review states the request was received 09/25/14. The RFA is not included. MTUS, Benzodiazepines, page 24 states, "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. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. "The reports show the patient started this medication 08/07/14 with #15 and 1 refill and the treating physician states use is for sleep. It appears the treating physician is now requesting for #30 on approximately 09/25/14. The reports do not state that use is intended for short term, and indicate use is for longer than the 4 weeks recommended by MTUS. The request IS NOT medically necessary.