

Case Number:	CM15-0201255		
Date Assigned:	10/16/2015	Date of Injury:	02/22/2012
Decision Date:	11/25/2015	UR Denial Date:	09/29/2015
Priority:	Standard	Application Received:	10/13/2015

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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

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 52 year old male, who sustained an industrial injury on 2-22-2012. Medical records indicate the worker is undergoing treatment for cervical and lumbar disc herniation with radiculitis-radiculopathy and left hip surgery. A recent progress report dated 6-9-2015, reported the injured worker complained of low back pain and left hip pain rated 9 out of 10. Physical examination revealed positive lumbar straight leg raise test bilaterally. Treatment to date has included physical therapy Hydrocodone and Oxycodone (since at least 6-9-2015). On 8-14-2015, the Request for Authorization requested Oxycodone 10-325mg #120 and new chair walker. On 9-29-2015, the Utilization Review noncertified the request for Oxycodone 10-325mg #120 and new chair walker.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, specific drug list. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) and Pain, Opioids.

Decision rationale: Oxycodone is the generic version of Oxycontin, which is a pure opioid agonist. ODG does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage, with treatment since at least 6/15. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. Further the prior review notes that weaning of this medication has been recommended, this would be appropriate. As such the request for Oxycodone 10/325mg #120 is deemed not medically necessary.

New chair walker: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ankle & Foot (online version), Rolling knee walker.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Durable Medical Equipment (DME) and Exercise Equipment and Other Medical Treatment Guidelines Medicare.gov, durable medical equipment.

Decision rationale: MTUS and ACOEM are silent regarding the medical necessity of chair walkers. ODG does state regarding durable medical equipment (DME), "Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below" and further details "Exercise equipment is considered not primarily medical in nature". Medicare details DME as: durable and can withstand repeated use, used for a medical reason, not usually useful to someone who isn't sick or injured, appropriate to be used in your home. The request for walker likely meets the criteria for durability and home use per Medicare classification, although the request is non-specific. The treating physician provides little comment on what medical reasons that would necessitate a walker for this IW. However, there is notation of previous use of a four wheel walker though the available medical record does not indicate why a chair walker is currently being requested as a replacement. While the record does not provide a full evaluation as to need as this is a replacement in this specific case, a walker is classified as durable medical equipment and would be recommended as a continuing mobility aid. As such, I am reversing the prior review and the request for a chair walker is deemed medically necessary.