

<b>Case Number:</b>	CM15-0040892		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	10/08/1993
<b>Decision Date:</b>	04/21/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2015

### 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: Physical Medicine & Rehabilitation

### 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 66-year-old female, who sustained an industrial injury on October 8, 1993. She has reported left knee pain. Diagnoses have included left total knee arthroplasty and revision. Treatment to date has included medications, physical therapy, total knee arthroplasty and revision. A progress note dated December 23, 2014 indicates the injured worker was doing well following the knee revision. The treating physician documented a plan of care that included medications, continuation of home exercise, and restarting physical therapy, as the injured worker felt it was beneficial.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 10 mg QTY: 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** Per the 02/12/15 report, the patient presents with range of motion and falling complaints s/p TKA revision and re-implantation. The current request is for OXYCONTIN 10mg QYT: 60: Oxycodone, an opioid. The RFA is not included; however, the 02/12/15 utilization review states the request is per the order dated 02/04/15. The patient is retired. 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 provided for review show that this medication have been prescribed since at least 09/09/14. On 02/12/15 the treating physician states that the patient's best pain is 3/10 with use of Percocet/Oxycontin; however, the MTUS guidelines require much more thorough documentation of analgesia with before and after pain scales and functional improvements with opioid usage. Pain scales are not routinely used to assess pain and no specific ADL's are mentioned to show a significant change with use of this medication. Adverse side effects and adverse behavior are not discussed. No UDS's are provided for review or documented nor is there mention of CURES. In this case, the 4A's have not been documented as required by the MTUS guidelines. The request IS NOT medically necessary.

**Hydrocodone 5/325 mg QTY: 90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** Per the 02/12/15 report, the patient presents with range of motion and falling complaints s/p TKA revision and re-implantation. The current request is for HYDROCODONE 5/325mg QYT 90 an opioid. The RFA is not included; however, the 02/12/15 utilization review states the request is per the order dated 02/04/15. The patient is retired. 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 provided for review from 09/09/14 to 02/12/15 do not discuss this medication; however, they do show the patient has been prescribed an opioid/Oxycodone/Percocet, since at least 09/09/14. On 02/12/15 the treating physician states that the patient's best pain is 3/10 with use of Percocet; however, the MTUS guidelines require much more thorough documentation of analgesia with before and after pain scales and functional improvements with opioid usage. Pain scales are not routinely used to assess pain and no specific ADL's are mentioned to show a significant change with use of this medication. Adverse side effects and adverse behavior are not discussed. No UDS's are provided for review or documented nor is there mention of CURES. In this case, the 4A's have not been documented as required by the MTUS guidelines. The request IS NOT medically necessary.

**Lorazepam 1 mg QTY: 90: Upheld**

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

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

**Decision rationale:** Per the 02/12/15 report, the patient presents with range of motion and falling complaints s/p TKA revision and re-implantation. The current request is for LORAZEPAM 1mg QTY: 90 Benzodiazepine. The patient is retired. 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 02/12/15 report states this medication is for sleep. The reports provided for review show the patient have been prescribed this medication on a long-term basis since at least 09/09/14. Use of Lorazepam has already exceeded the recommendation of the MTUS guidelines for short-term use of no more than 4 weeks, and this request is for an additional # 90. Therefore, the request IS NOT medically necessary.

**Zolpidem 10mg QTY: 30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain, insomnia treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Mental Illness and Stress Chapter, Ambien/Zolpidem.

**Decision rationale:** Per the 02/12/15 report, the patient presents with range of motion and falling complaints s/p TKA revision and re-implantation. The current request is for ZOLPIDEM 10mg QTY: 30. The patient is retired. MTUS and ACOEM Guidelines do not address Ambien; however, ODG Mental Illness and Stress Chapter, Ambien/Zolpidem, state that Ambien is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. The 02/12/15 report states that this medication is for sleep. The currently requested medication is indicated for insomnia; however, the reports provided for review do not otherwise discuss sleep issues for this patient and no diagnosis of insomnia/difficulty of sleep onset is provided. The treating physician does not state whether the medication helps the patient. Furthermore, the MTUS guidelines state use is indicated for the short-term of 7-10 days, and the reports provided show the patient has been prescribed this medication on a long-term basis since at least 09/09/14. In this case, the request IS NOT medically necessary.