

Case Number:	CM13-0018464		
Date Assigned:	01/22/2014	Date of Injury:	05/22/1998
Decision Date:	08/27/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	08/29/2013

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 Physical Medicine & Rehabilitation 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 injured worker is a 63-year-old female who reported an injury on 05/22/1988. The injured worker underwent x-rays and physical therapy. The injured worker underwent multiple surgical interventions for the bilateral knees and underwent a cervical spine fusion on 09/07/2010. Additionally, the injured worker was given intramuscular injections, including steroids. The injured worker's medication history included opiates as of at least 08/2013. The mechanism of injury was cumulative trauma. The injured worker underwent MRIs. The documentation of 04/04/2014 revealed that the injured worker had increasing pain to the bilateral knees. The injured worker complained of pain to her low back that radiated down the lateral aspect of the bilateral lower extremities. The injured worker indicated that she continued to use Duragesic patches in conjunction with Norco, which was noted to bring her pain to a manageable level. The injured worker indicated that without her current medications, she would be housebound and unable to perform activities of daily living. The diagnoses were noted to be rotator cuff tear; postlaminectomy syndrome, lumbar region; depressive disorder, not elsewhere classified; opioid type dependence, unspecified; reflex sympathetic dystrophy of the lower limb; spinal stenosis, lumbar region without neurogenic claudication; total knee replacement; other symptoms referable to back; and primary localized osteoarthritis of the lower leg. The treatment plan included a urine drug screen, an epidural steroid injection and Duragesic 25 mcg/hr transdermal patch at 1 patch every 72 hours for 30 days and Norco 10/325 mg 0.5 tablet 3 times a day for 30 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE/ACETAMINOPHEN 10/325 QTY 45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and ongoing management Page(s): 60-78.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement and documentation of an objective decrease in pain. There should be documentation that the injured worker is being monitored for aberrant drug behaviors and side effects. The clinical documentation submitted for review indicated that the injured worker had utilized opioids since at least 08/2013. There was a lack of documentation of objective functional improvement and an objective decrease in pain. There was a lack of documentation of a DWC form RFA or PR-2 for the requested medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for hydrocodone/acetaminophen 10/325 (Quantity: 45.00) is not medically necessary.

FENTANYL PATCH MCG/HR QTY 15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and ongoing management Page(s): 60-78.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement and documentation of an objective decrease in pain. There should be documentation that the injured worker is being monitored for aberrant drug behaviors and side effects. The clinical documentation submitted for review indicated that the injured worker had utilized opioids since at least 08/2013. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Fentanyl patch mcg/hr (Quantity: 15.00) is not medically necessary.

METHYLPREDISOLONE 4 MG QTY 21: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS Treatment Page(s): 37.

Decision rationale: The California MTUS Guidelines indicate that corticosteroids are commonly used for CRPS. There was no DWC Form RFA or PR-2 submitted with the request

for the medication. There was no documented rationale for the request. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the frequency. Given the above, the request for methylprednisolone 4 mg (Quantity: 21.00) is not medically necessary.