

Case Number:	CM14-0089153		
Date Assigned:	07/23/2014	Date of Injury:	08/08/2001
Decision Date:	09/29/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/13/2014

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 and is licensed to practice in Nevada. 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 48 year-old female who was reportedly injured on 8/8/2001. The mechanism of injury is noted as falling off a chair. The most recent progress note dated 5/12/2014. Indicates that there are ongoing complaints of neck pain that radiates into the bilateral shoulders with numbness and tingling in the bilateral wrist. Low back pain radiating into the bilateral lower extremities. Left knee pain. The physical examination demonstrated bilateral shoulders: decreased range of motion. Mildly positive impingement sign on the right. Lumbar spine: forward flexion antalgic gait. Positive tenderness to palpation of the bilateral greater trochanters. Decreased sensation of the left L5 and bilateral S1 dermatomes. Limited range of motion with extension and right lateral bending. Reflexes 1+ bilateral lower extremities. Muscle strength 5/5 bilateral lower extremities. No recent diagnostic studies are available for review. Previous treatment includes shoulder arthroscopy, medications, lumbar fusion, and conservative treatment. A request was made for Augmentin 875 mg #20, Duragesic patch 100mcg #15, OxyContin 40 mg #180 and was not certified in the pre-authorization process on 6/3/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Augmentin 875 mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MICROMEDEX Gateway for Medical Review Institute of America Augmentin, FDA Labeled Indications.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infectious Diseases. Augmentin. Updated 6/26/2014.

Decision rationale: Official Disability Guidelines (ODG) recommends Augmentin as first-line treatment for vitamins and other conditions. After review of the medical records provided it is noted injured worker is pending an expedited hearing regarding consultation by an oral specialists in regards to dental treatment. However there is no documentation stating the claimant has been treated for authorized care. Therefore, the request for Augmentin 875 mg #20 is not medically necessary and appropriate.

Oxycontin 40 mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 75, 78, 92, & 97.

Decision rationale: California MTUS Guidelines support long-acting opiates like OxyContin in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no documentation of improvement in their pain level or function with the current treatment regimen. In the absence of subjective or objective clinical data, the request for Oxycontin 40 mg #180 is not medically necessary and appropriate.

Duragesic Patch 100mcg/hr #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system); Opioids, criteria for use Page(s): 44, 75-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 93.

Decision rationale: California Medical Treatment Utilization Schedule guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Treatment guidelines specifically state Fentanyl is "not recommended for musculoskeletal pain." Review of the available medical records, fails to document improvement in pain or function with the current treatment regimen. Given the date of injury, clinical presentation and current

diagnosis, the request for Duragesic Patch 100mcg/hr #15 is not medically necessary and appropriate.