

<b>Case Number:</b>	CM14-0211538		
<b>Date Assigned:</b>	12/24/2014	<b>Date of Injury:</b>	10/09/2012
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2014

### 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. 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, Arizona  
 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 53-year-old male who reported an injury on 10/09/2012. The mechanism of injury was the injured worker's knee was struck by a slow moving vehicle. The medications were noted to include gabapentin 300 mg at bedtime, oxycodone 20 mg 3 times a day, and Protonix 40 mg daily. The injured worker underwent a left knee arthroscopic chondroplasty on 08/14/2014. Therapies included physical therapy. The diagnostic studies were noted to include an x-ray which revealed no fracture and revealed joint effusion. The documentation of 11/20/2014, revealed the injured worker stated "if I don't take my pain medications, I can't stand the pain." The clinical documentation indicated the injured worker's diagnosis included depression, insomnia, muscle mass atrophy and loss and left knee pain. The injured worker was noted to be an active smoker. The treatment plan included a refill of medications and additional physical therapy. The Request for Authorization submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 20mg 1 PO TID #90:** 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; ongoing management Page(s): 60; 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effect. There was a lack of documentation indicating the injured worker had objective functional improvement, an objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior side effects. Given the above, the request for oxycodone 20 mg 1 by mouth 3 times a day #90 is not medically necessary.

**Protonix 40mg 1 PO QD #30 Refills: 3: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that proton pump inhibitors are recommended for injured workers at intermediate or high risk for gastrointestinal events. The clinical documentation submitted for review indicated the injured worker had previously utilized the medication. There was a lack of documentation indicating the necessity for 3 refills without re-evaluation. There was a lack of documented efficacy for the requested medication. Given the above, the request for Protonix 40 mg 1 by mouth daily #30, refills 3, is not medically necessary.