

Case Number:	CM15-0172136		
Date Assigned:	09/14/2015	Date of Injury:	05/16/1996
Decision Date:	10/19/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/01/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 69 year old female with a date of injury of May 16, 1996. A review of the medical records indicates that the injured worker is undergoing treatment for failed back surgery syndrome of the lumbar spine, and continued superficial redness with no change. Documentation (August 11, 2015) indicates that the injured worker had recently complete chemotherapy for colon cancer. Medical records dated August 11, 2015 indicate that the injured worker complains of lower back pain, still sore from the pocket revision, continued redness. Pain is rated at a level of 10 out of 10. Records also indicate the injured worker is using a walker, is able to sit for 0 to 2 minutes, is unable to stand, walks 0 to 20 minutes, has variable sleep, is independent with activities of daily living and does not drive. A progress note dated July 1, 2015 notes subjective complaints of lower back pain and taking antibiotics for a superficial skin infection. The physical exam dated August 11, 2015 reveals positive erythema at the lower left quadrant pump location without tenderness or swelling, and tenderness of the left shoulder (noted to be non-industrial). The progress note dated July 1, 2015 documented a physical examination that showed erythema at the left lower quadrant pump location that is improving, and mild warmth of the area. Treatment has included (pain pump (Fentanyl 8000mcg per cc- Bupivacaine 5mg per cc), medications (Oxycodone 30mg since at least February of 2014), and back surgery. The treating physician indicates that the goal was to decrease the Oxycodone use. The original utilization review (August 20, 2015) non-certified a request for Oxycodone 30mg #180 and Voltaren gel 1%.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 30mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding ongoing management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the '4 A's' (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the available medical records reveals no documentation to support the medical necessity of oxycodone nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. The medical records contain evidence of ongoing UDS, the latest UDS report dated 7/24/15 was consistent with prescribed medications. As MTUS recommends to discontinue opioids if there is no overall improvement in function, medical necessity cannot be affirmed. Furthermore, the medical records indicate that in addition to pain pump, the injured worker's morphine equivalent dose is 270, which exceeds the guideline recommended 120 MED.

Voltaren gel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Voltaren gel, Diclofenac.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: With regard to topical NSAIDs, MTUS states, "These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term

use (4-12 weeks)." There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Voltaren Gel 1% specifically is "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Per the guidelines, the indications of this medication are limited to joints that are amenable to topical treatment. The documentation submitted for review does not denote any indications for the request. The request is not medically necessary.