

Case Number:	CM15-0176221		
Date Assigned:	09/17/2015	Date of Injury:	03/15/2000
Decision Date:	10/20/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/08/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 injured worker is a 47 year old male, who sustained an industrial injury on 03-15-2000. The injured worker was diagnosed as having reflex sympathetic mediated pain syndrome and bilateral knee pain. On medical records dated 07-28-2015 and 06-29-2015, subjective complaints were noted as bilateral knee pain that radiates legs bilaterally. Pain level was 10 out of 10 without pain medication and 7-8 with medication. The injured worker was noted to be able to perform activities of daily living with medication regimen, noted as walk, clean around the house, self-care and to play with his grandchildren. The objective findings were noted as having severe allodynia to light touch medial and lateral aspect left patella, moderate to severe allodynia to light touch diffuse right knee, decreased range of motion, right and left knee flexion and extension due to pain and a slow unsteady gait was noted. Treatment to date included: medication, physical therapy, and intra-articular knee injection. Current medication was listed as Celebrex, Fentanyl Patch, Gabapentin, Percocet and Omeprazole. The provider was noted to have discontinued Percocet during visit and prescribe Oxycodone. The Utilization Review (UR) was dated 08-31-2015. A Request for Authorization was dated 07-01-2015 requested Oxycodone 15mg to improve pain and function, a walker with a seat to improve stability and function. The UR submitted for this medical review indicated that the request for Oxycodone 15 mg #120 and walker was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Oxycodone 15mg #120: 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 for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Opioids.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, one prescription Oxycodone 15 mg #120 is not medically necessary. Ongoing, chronic opiate use requires an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. A detailed pain assessment should accompany ongoing opiate use. Satisfactory response to treatment may be indicated patient's decreased pain, increased level of function or improve quality of life. The lowest possible dose should be prescribed to improve pain and function. Discontinuation of long-term opiates is recommended in patients with no overall improvement in function, continuing pain with evidence of intolerable adverse effects or a decrease in functioning. The guidelines state the treatment for neuropathic pain is often discouraged because of the concern about ineffectiveness. In this case, the injured workers working diagnoses are reflex sympathetic mediated pain syndrome; and bilateral knee strain. The date of injury is March 5, 2000. Request for authorization is August 4, 2015. According to a progress note dated December 30, 2014, medications prescribed include Percocet 10/325 (Oxycodone), Fentanyl 75 g, Omeprazole and Celebrex. According to the most recent progress note dated July 28, 2015, subjectively the injured worker complained of bilateral knee pain radiating to the legs. Pain score was 5/10. The injured worker states pain has increased since returning back to work, although there have been no changes in medications. Objectively, there was no physical examination except for severe decreased range of motion in the right and left knee into flexion and extension with a slow unsteady gait. The documentation does not demonstrate objective functional improvement to support ongoing oxycodone. There are no detailed pain assessments or risk assessments in the medical record. Based on the clinical information and medical records, peer-reviewed evidence-based guidelines no documentation demonstrating objective functional improvement and no detailed pain assessments or risk assessments to support ongoing opiate use, one prescription Oxycodone 15 mg #120 is not medically necessary.

1 Walker: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (acute & Chronic) Walking Aids (Canes, Crutches, Braces, Orthoses, & Walkers).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg section, Walking aids, DME.

Decision rationale: Pursuant to the Official Disability Guidelines, one walker is not medically necessary. Durable medical equipment is recommended generally if there is a medical need and the device or system meets Medicare's definition of durable medical equipment. The term DME is defined as equipment which: can withstand repeated use; is primarily and customarily served medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in the patient's home. Disability, pain and related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome and negative evaluation of the walking aid. Assistive devices for ambulation can reduce pain with osteoarthritis. In this case, the injured workers working diagnoses are reflex sympathetic mediated pain syndrome; and bilateral knee strain. The date of injury is March 5, 2000. Request for authorization is August 4, 2015. According to a progress note dated December 30, 2014, medications prescribed include Percocet 10/325 (Oxycodone), Fentanyl 75 g, Omeprazole and Celebrex. According to the most recent progress note dated July 28, 2015, subjectively the injured worker complained of bilateral knee pain radiating to the legs. Pain score was 5/10. Objectively, there was no physical examination except for severe decreased range of motion in the right and left knee into flexion and extension with a slow unsteady gait. According to a July 8, 2015 utilization review, utilization review #3030154, a walker with seat was certified. There is no clinical indication or rationale in the medical record for a second walker with seat. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, prior certification for a walker with seat and no clinical indication for a second walker with seat, one walker is not medically necessary.