

Case Number:	CM15-0093994		
Date Assigned:	05/21/2015	Date of Injury:	08/16/2006
Decision Date:	06/24/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/18/2015

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

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 67 year old male with an industrial injury dated 08/16/2006 and 12/01/2006 .His diagnoses included chronic low back pain, status post lumbar laminectomy and fusion, left knee arthroplasty, status post revision; headaches, opioid dependence and depression associated with chronic pain. Prior treatments included medications, massage treatment, bio freeze, H wave, surgery and psychiatrist. He presents on 04/01/2015 with complaints of chronic neck, shoulder, left knee and low back pain with radiation down both legs. He reports increased frequency where both legs give out and he admits to having more falls. He rated the pain as 6/10. He was taking OxyContin twice daily for long acting pain relief. He was averaging 4 tablets of Roxicodone daily for breakthrough pain. The OxyContin and Percocet help bring his pain down from a 10+/10 to a 6-7/10. According to documentation the medications enable him to perform activities of daily living including washing dishes, vacuuming and gardening. He denies any side effects. The provider documents most recent urine drug screen from 03/04/2015 was consistent with prescribed analgesics. He lists allergies as nonsteroidal anti-inflammatory drugs and cortisone. Physical exam noted moderate discomfort with slow gait and 4 wheel walker for assistance. There was moderate to severe tenderness to palpation of the lumbar paraspinal muscles. Lumbar spine testing showed severely limited range of motion in flexion and extension. There was limited range of motion of the left knee. The injured worker reported relief with massage treatment but said the Bio freeze and H wave were no longer providing him additional pain relief. The treating physician is requesting a refill of OxyContin 15 mg one tab every 12 hours # 60 for long acting pan relief, refill Roxicodone 15 mg 1 tab every 4-6 hours for pain #

135, continue using H wave for non-pharmacologic pain relief and to minimize medication use, continue osteoarthritis knee brace to left knee, physical therapy with massage 2-3 times/week times 10 sessions to help alleviate low back pain and lumbar radiculopathy, pain psychologist, psychiatry follow and return visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Roxicodone 15mg #135: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids Page(s): 88-89, 76-78.

Decision rationale: The patient was injured on 06/16/06 and presents with low back pain, neck pain which radiates to the arms with an unbalanced gait, and headaches. The request is for ROXICODONE 15 MG #135 for breakthrough pain. There is no RFA provided and the patient is permanent and stationary. Treatment reports are provided from 11/05/14 to 04/20/15. The patient has been taking this medication as early as 02/04/15. MTUS Chronic Pain Medical Treatment Guidelines pages 88-89, "criteria for use of opiates for long-term users of opiates (6 months or more)" states, "pain should be assessed at each visit, and functioning should be measured at 6- month intervals using a numerical scale or validated instrument." MTUS page 78 criteria for use of opiates, ongoing management also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. The 03/04/15 report states that the patient had the "most recent UDS from 06/24/2014 [which] did not show any evidence of illicit drug use." He currently rates the pain a 7-7.5/10. The 03/23/15 report states that the patient rates his pain as an 8.5/10. The 04/01/15 report states that "the medications enable him to perform activities of daily living including dishes, vacuuming, and gardening. Denies any excessive sedation, nausea, or vomiting associated with the analgesic medications." There appears to be documentation of the four A's and the patient has had lumbar fusion with nociceptive chronic low back pain for which use of opiates may be indicated. Given the analgesia, general documentation of ADL's, UDS and no significant adverse effects, the request IS medically necessary.

Physical therapy x 10 for the low back: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: The patient was injured on 06/16/06 and presents with low back pain, neck pain which radiates to the arms with an unbalanced gait, and headaches. The request is for PHYSICAL THERAPY X 10 FOR LOW BACK to help alleviate low back pain and lumbar radiculopathy. There is no RFA provided and the patient is permanent and stationary. MTUS pages 98 and 99 have the following: Physical medicine: Recommended as an indicated below. Allow for fading of treatments frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS Guidelines pages 98 and 99 state that for myalgia, myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits are recommended. The patient has a slow antalgic gait, uses a 4 wheel walker for assistance, moderate to severe tenderness to palpation of the lumbar paraspinal muscles, a limited range of motion for the lumbar spine, a limited range of motion of the left knee, a positive straight leg raise bilaterally, and diminished sensation to light touch on the anterior/lateral aspect of the left lower extremity compared to the right. The patient is diagnosed with chronic low back pain, status post lumbar laminectomy and fusion, left knee arthroplasty, status post revision; headaches, opioid dependence and depression associated with chronic pain. Prior treatments included medications, massage treatment, bio freeze, H wave, surgery and psychiatrist. There is no indication of any recent surgery the patient may have had, and there is no discussion regarding why the patient is unable to establish a home exercise program to manage his pain. Given that the patient has not had any recent therapy, a course of therapy may be reasonable to help with chronic pain and the patient's decline in function. The requested 10 sessions of therapy IS medically necessary.

Massage therapy x 10 for the low back: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines massage therapy Page(s): 60.

Decision rationale: The patient was injured on 06/16/06 and presents with low back pain, neck pain which radiates to the arms with an unbalanced gait, and headaches. The request is for MASSAGE THERAPY X 10 FOR LOW BACK to help alleviate low back pain and lumbar radiculopathy. There is no RFA provided and the patient is permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines, page 60 for Massage therapy states: "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases." The patient has a slow antalgic gait, uses a 4 wheel walker for assistance, moderate to severe tenderness to palpation of the lumbar paraspinal muscles, a limited range of motion for the lumbar spine, a limited range of motion of the left knee, a positive straight leg raise bilaterally, and diminished sensation to light touch on the anterior/lateral aspect of the left lower extremity compared to the right. The patient is diagnosed with chronic low back pain, status post lumbar laminectomy and fusion, left knee arthroplasty, status post revision; headaches, opioid dependence and depression associated with chronic pain. Prior treatments included medications, massage treatment, bio freeze, H wave, surgery and psychiatrist. In this case, the treater does not discuss massage therapy history and how the patient responded to massage. No current flare-up, exacerbation or new injury is reported either to consider additional treatment. The request IS NOT medically necessary.