

Case Number:	CM13-0044841		
Date Assigned:	12/27/2013	Date of Injury:	11/23/1999
Decision Date:	03/11/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	10/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 physician 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 patient was a 48-year-old male who sustained an injury on 11/23/1999 when he was pulling out a 300 pound joint from a worksite. The patient indicated that he had subsequent burning around his waist and low back pain with radiation to his left leg. The patient underwent an MRI on 07/05/2013 of the lumbar spine which indicated the patient had degenerative changes at the L1-2, L3-4, L4-5 and L5-S1 levels. The MRI submitted for review further indicated the patient had left L3 and left L4 laminectomy defects, mild narrowing at the right lateral recess and severe right neural foraminal narrowing at the L5-S1 level, with encroachment on the exiting right L5 nerve secondary to a 6 mm broad right paracentral/right foraminal protrusion, and the degree of narrowing of the right lateral recess that this level had progressed since the prior MRI on 05/12/2004. The report further indicated the patient had degenerative disc disease at the L4-5 level, where there is a concentric bulge with a superimposed 7 mm left paracentral protrusion which moderately posteriorly displaces the left central L5 nerve root in the left lateral recess and causes mild spinal canal stenosis, severe narrowing of the left lateral recess, moderate narrowing of the right lateral recess, and moderate to severe left neural foraminal narrowing with encroachment on the exiting left L4 nerve root, and the enhancing granulation tissue in the left lateral recess at this level no longer apparent compared to the prior MRI on 05/12/2004. The report continued with findings of degenerative disc disease at the L3-4 level, where there is a concentric bulge with a 5 mm left paracentral component which mildly posteriorly displaces the left central L4 nerve root in the left lateral recess and causes mild spinal canal stenosis, moderate left greater than right narrowing of the lateral recesses and mild left neural foraminal narrowing. The patient was seen on 12/07/2013 which indicated the patient was seen for severe left leg pain with radiculopathy 8/10 without medications. It is additionally noted that the documentation submitted for review is in large part illegible.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) prescription of Oxycodone; 30 mg #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids, page(s) 74-78 Page(s): 74-78.

Decision rationale: The request for One (1) prescription of oxycodone 30 mg #240 is non-certified. The California MTUS Guidelines indicate the use of opioids be based on pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potential aberrant or non-adherent drug related behaviors. The documentation submitted for review did not indicate the analgesic effect of the medications requested. It was noted per documentation submitted for review that the patient's pain was 8/10 without medications; however, the documentation dated 10/08/2013 indicates the patient had relief to 3/10 with the use of Neurontin 300 mg for his burning to the left leg. The documentation dated 12/07/2013 indicated the use of oxycodone 30 mg with unclear dosage and OxyContin 20 mg twice a day and Neurontin 300 mg 2 tablets 3 times a day to decrease leg pain to 3 of 10 and walk with a limp. Per the documentation submitted for review there was no change in the patient's status with the addition of 2 medications as was with the Neurontin alone. Furthermore, the documentation submitted for review did not indicate the patient's functional ability and the effects the medication were having on his physical and psychosocial functioning. The guidelines recommend an assessment to include current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid and how long it takes for pain relief. The documentation submitted for review did not have noted response to treatment in relation to the patient's level of functioning or improved quality of life. Given the information submitted for review the request for One (1) prescription of oxycodone 30 mg #240 is non-certified.