

Case Number:	CM13-0063523		
Date Assigned:	12/30/2013	Date of Injury:	01/12/2000
Decision Date:	05/23/2014	UR Denial Date:	11/15/2013
Priority:	Standard	Application Received:	12/09/2013

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 Internal 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 is a 56 year old female who sustained an injury on 04/07/02. The patient's mechanism of injury was not documented. The patient was seen on 08/07/13 by [REDACTED]. The patient is noted to be status post right total knee replacement with subsequent chronic right knee pain. The patient was also diagnosed with chronic mid and low back pain as well as failed back surgery syndrome following an L4-5 procedure in 1987. Per the clinical report, the patient was unable to utilize anti-inflammatories or over the counter Tylenol due to GI issues. She was utilizing Neurontin and Cymbalta and recently underwent radiofrequency ablation on 04/18/13 which resulted in 50% pain relief and functional improvement with decreased medication use. The patient indicated that with medications, her pain levels were 3-4/10 and without medications they were 10/10. Clinical note dated 10/30/13 indicated the patient complained of chronic, severe left neck pain radiating to the head and shoulder and at times into the hand with associated numbness and tingling. The patient also complained of thoracic and lumbar pain and knee pain. The patient's physical examination demonstrated tenderness to palpation in the cervical, thoracic, and lumbar paraspinals. There was decreased strength in the upper and lower extremities. Reflexes were noted to be trace to absent at the left ankle and 1+ to 2+ otherwise. According to the report, the patient's last urinary drug testing and CURES reports were appropriate. Medications at this visit included Methadone, Oxycodone, Soma, Cymbalta, Restoril, Neurontin, and Trazodone. The treating provider has requested Oxycodone HCL 10mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

OXYCODONE HCL 10 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION OPIOIDS FOR CHRONIC PAIN.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION OPIOIDS, CRITERIA FOR USE Page(s): 77.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. The previous utilization review indicates the employee was approved for Oxycodone HCL 10mg #120. There is no indication in the documentation that the employee is not receiving adequate pain control with the current medication regimen requiring an additional prescription of Oxycodone HCL. Medical necessity for the requested item has not been established. The requested item is not medically necessary.