

Case Number:	CM14-0009536		
Date Assigned:	02/14/2014	Date of Injury:	11/14/2003
Decision Date:	06/27/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/23/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/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:

This is a 50-year-old-year male patient with a 11/14/2003 date of injury. The patient fell backwards on concrete. He stated that he was getting progressively worse since then. The 01/25/2013 progress report indicated low back pain radiating to the lower extremities, aggravated by lifting, pushing, pulling, twisting, and turning. The 12/09/2003 lumbar MRI (magnetic resonance imaging) showed degenerative disc disease at L3-4, L4-5, and L5-S1 and disc bulging with neural foraminal outlet narrowing on the right. He had an epidural steroid injection. The 12/29/2003 progress report indicated that the epidural was quite helpful after about 3 days. Physical exam indicated that the patient was more flexible. The 05/24/2011 progress report indicated pain and weakness in the left knee. There was occasional popping and grinding sensation in the left knee, which was aggravated with rotation. He could not fully flex the knee and fully squat. 07/10/2013 progress report indicated that the right knee was getting worse. He was wearing a right knee brace; his right shoulder was getting worse. He was diagnosed with a rotator cuff tear, sprain of knee and leg, lumbosacral neuritis. The treatment included repeat right knee surgery, arthroscopy and anterior cruciate ligament (ACL) repair, and Oxycodone 30mg #180. The 09/24/2013 progress report demonstrated prescriptions for Oxycodone 30mg #150 and Celebrex 200mg #30. The 10/16/2013 progress report indicated that patient complained of severe pain, inability to walk. The treatment plan indicated to increase quantity of Oxycodone to 180 again. The 12/09/2013 progress report indicated that medication helped him, but he still cannot walk for a long time due to right knee pain. The treatment included Oxycodone 30mg # 150. There is documentation of a previous adverse determination on 01/06/2014, with modification of oxycodone 30mg #45 due to weaning process initiation; with reduction of 25% of quantity, and continuation to reduce every month by 25%.

IMR ISSUES, DECISIONS AND RATIONALES

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

PROSPECTIVE REQUEST FOR 1 PRESCRIPTION OF OXYCODONE 30 MG #150:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone, and Section Criteria for use of Opioids Page(s): 78-81.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed, are prescribed at the lowest possible dose, and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, the patient presented with severe pain in lower back, shoulder area. He was prescribed with Oxycodone 30mg #180, which tapered during the months of treatment. His last prescription on a 12/27/2013 included Oxycodone 30mg #150. The last request was modified to #45 to provide for a weaning process; and doses were reduced by 25% in each prescription. In addition, the record did not clearly reflect absence of adverse side effect or aberrant behavior of opiate use. Therefore, the prospective request for one (1) prescription of oxycodone 30mg, #150 was not medically necessary.