

Case Number:	CM14-0013409		
Date Assigned:	02/26/2014	Date of Injury:	11/05/2012
Decision Date:	06/26/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/03/2014

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 Orthopaedic Surgery 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:

The records presented for review indicate that this 48-year-old individual was injured in November 2012. Treatment to date has included electrodiagnostic studies, imaging studies of the brain, knee and cervical spine. The current diagnosis is cervical disc disease (722.0). A September 2013 qualified medical evaluation report noted the injured worker to be permanently stationary. The mechanism of injury is noted as a motor vehicle collision. The progress note at the same time noted ongoing complaints of neck pain and radiation into the upper extremity. Additionally, there were complaints of right shoulder and left knee pain. The physical examination of the cervical spine noted tenderness to palpation, muscle spasm and a reduced cervical spine range of motion. Motor strength was noted to be weak and sensation was decreased. The injured worker is reported to be 5'7" 194 pounds. Electrodiagnostic testing indicated no evidence of a radiculopathy. Degenerative changes in the shoulder were noted on MRI.

IMR ISSUES, DECISIONS AND RATIONALES

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

OXYCONTIN ER 40 MGM 1 TAB PO TID, #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS; OPIOIDS FOR CHRONIC PAIN SPECIFIC DRUG LIST Page(s): 86; 91.

Decision rationale: According to Chronic Pain Medical Treatment Guidelines, this preparation is indicated for continuous, around-the-clock analgesic purposes and not as an as needed (PRN) preparation. When noting the mechanism of injury and the findings on imaging study and electrodiagnostic assessment, there is no clinical indication presented of the need for a chronic, continuous oral analgesic medication. Furthermore, the records review does not reflect that there has been any significant improvement, amelioration of the pain complaints, or an ability to return to work or increased functionality. This medication demonstrates no efficacy or utility. Recommend not medically necessary.

OXYCODONE 15 MG 1-3 TABS POQ 3-4 HRS PRN: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS; OPIOIDS FOR CHRONIC PAIN SPECIFIC DRUG LIST Page(s): 86; 91.

Decision rationale: According to Chronic Pain Medical Treatment Guidelines, this preparation is indicated for continuous, around-the-clock analgesic purposes and not as an as needed (PRN) preparation. When noting the mechanism of injury and the findings on imaging study and electrodiagnostic assessment, there is no clinical indication presented of the need for a chronic, continuous oral analgesic medication. Furthermore, the records review does not reflect that there has been any significant improvement, amelioration of the pain complaints, or an ability to return to work or increased functionality. This medication demonstrates no efficacy or utility. Recommend not medically necessary.