

Case Number:	CM14-0015346		
Date Assigned:	02/28/2014	Date of Injury:	07/16/2007
Decision Date:	07/03/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/06/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 42-year-old male who reported an injury on 07/16/2007 secondary to an unknown mechanism of injury. The injured worker was evaluated on 12/10/2013 for reports of pain to the right side of his back radiating down his right leg. He also reported burning sensation in his leg and numbness in the 3rd, 4th, and 5th toes. The injured worker rated the pain at 8/10. The injured worker reported 50% functional improvement with the medication versus not taking them. The exam noted forward flexion of 30 degrees and extension at 5 degrees. Muscle spasm was noted along with bilateral positive straight leg raise. The exam further noted disuse atrophy to the right thigh and calf. Furthermore, allodynia and hypersensitivity to light touch and pinprick was noted along the right lateral calf, ankle, and foot. The right lower extremity was also noted to be very cold to touch in comparison to the left. The diagnoses included history of L4-5 spinal fusion, abnormal EMG of the right lower extremity revealing radiculopathy, neuropathic component of pain, and intermittent back spasms. Urine drug screens were noted to have been appropriate for the patient. The treatment plan included refilled medications. The request for authorization was found dated 12/12/2013 in the documentation provided. Rationale for the request was found in the chart notes.

IMR ISSUES, DECISIONS AND RATIONALES

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

OXYCODONE IR 15 MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The request for Oxycodone IR 15 mg #120 is non-certified. The California MTUS Guidelines recommend the use of opioids for the ongoing management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a significant lack of evidence of the objective assessment of the injured worker's pain level with and without medication and side effects. Furthermore, the request does not indicate the frequency of the medication. Therefore, based on the documentation provided, the request is non-certified.