

Case Number:	CM14-0129439		
Date Assigned:	09/16/2014	Date of Injury:	07/28/2009
Decision Date:	11/05/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/14/2014

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 Anesthesiology, 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 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 45 year old male who is reported sustained a work related injury on July 28, 2009. The injured worker is reported to have sustained an injury to his low back as a result of adjusting a part. Diagnosis is listed as chronic pain (338.2). The most recent clinical information dated 8/6/14 reveals low back pain. Pain is rated an 8 out of 10 on visual analog scale with medications and 10 out of 10 without medications. Physical examination revealed antalgic gait, slight difficulty transferring from sitting to standing, lumbar decreased range of motion, and tenderness with spasms. The records reflect that the injured worker has been treated with oral medications, physical therapy, chiropractic, and four right trochanteric bursa injections. The injured worker has been largely maintained on oral medications. The records indicate as signed pain management contract and appropriate urine drug screens. He is reported to be employed working full time and is participating in externship as a drug and alcohol counselor. Utilization review determination dated 08/12/14 in which a request for Oxycodone/Acetaminophen 10/325 milligrams quantity ninety was noncertified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone/Acetaminophen 10/325mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-83.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates
Page(s): 74-80.

Decision rationale: The request for Oxycodone/Acetaminophen 10/325mg #90 is recommended as medically necessary. The submitted clinical records indicate that the injured worker has chronic back pain which benefits from opiate medications. The records reflect that the injured worker is compliant and is employed full time. This is the single most important indicator of functional benefit and consistent with California Medical Treatment Utilization Schedule treatment recommendations. As such the medical necessity for continued use is established.