

Case Number:	CM14-0157547		
Date Assigned:	09/30/2014	Date of Injury:	10/08/2009
Decision Date:	12/03/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	09/25/2014

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:

Injured worker is a female with date of injury 10/8/2009. Per orthopedic progress note dated 8/19/2014, the injured worker reports that she had some dental work done and her dentist gave her ibuprofen, which she is taking 2-4 per day as instructed. She is still taking 2 Norco per day and 4 Percocet per day. She complains of back pain across the lumbar spine. Symptoms are described as aching, dull and pressure. Her pain is rated 8/10. The symptoms are alleviated by medication and exacerbated by walking, standing, sitting and all physical activities. Pain severity is reported as moderate. On examination there is severe tenderness to palpation at the left sciatic notch. Straight leg raise in the sitting position is positive on the left. Passive straight leg raise test is negative bilaterally. Sensation to light touch is intact. Gait is non-antalgic without ataxia. Diagnoses include 1) back pain 2) lumbar radiculopathy 3) pain in joint-ankle and foot 4) complex regional pain syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 5mg #120 x2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications section Page(s): 74-95, 124.

Decision rationale: The original request was for Oxycodone 5 mg tablet, 1 tablet by mouth four times daily for 3 days, total number 120 tablets. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical reports do not provide information regarding functional improvement or reduction in pain with the use of oxycodone. Aberrant drug behavior is not addressed. Information regarding attempts to treat with non-opioid medication and active therapy are not addressed. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Modify the request for Oxycodone 5mg #120 to allow the patient this one refill of Oxycodone 5mg #120 for the purpose of weaning to discontinue, with a reduction of MED by 10%-20% per week over a period of 2-3 months is determined to not be medically necessary.