

Case Number:	CM14-0165141		
Date Assigned:	10/10/2014	Date of Injury:	10/06/2000
Decision Date:	11/10/2014	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/07/2014

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 Pain Management 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 injured worker is a 58 year old female with a date of injury on 10/6/2000. The exact mechanism of injury is not specified. She was diagnosed with (a) post laminectomy syndrome of the lumbar spine, (b) left lower extremity radiculopathy, (c) status post spinal cord stimulator implant, (d) status post inpatient detox. In the most recent evaluation report dated September 11, 2014 it was indicated that she complained of constant sharp pain in her low back. The pain was increased by movement, cold weather, and laying down and was decreased by medication and rest. The physical examination revealed that she ambulated with the aid of a walker. The objective findings to the lumbar spine included tenderness over the paraspinous area, limited range of motion in all planes and presence of lumbar surgical scar. She was recommended to perform home exercise and stretching as well as to make a pain diary. She was to continue with her current pharmacological regimen. Authorization for physical therapy at a frequency of once a week for six weeks was requested. This is a review of the requested Oxycontin instant release 20mg, #150.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone IR 20mg #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Page(s): 78-80.

Decision rationale: Oxycodone instant release or oxycodone extended-release is a narcotic analgesic (opioid) which is used to relieve moderate to severe pain. The Chronic Pain Medical Treatment Guidelines indicate that ongoing management of chronic pain with opioid medications if there is documentation of overall improvement in pain levels and functioning, documentation of misuse of medications, use of drug screening, continuing review of overall situation with regard to non-opioid means of pain control and if there are indications of extenuating circumstances. Absent in the documentation is the quantitative measures or objective findings of functional improvement such as decreased in pain levels or increase in the performance of activities of daily living with its continued use. Additionally, there is nothing in the records that documents the use of a drug screening regarding issues of abuse, addiction or poor pain control, documentation of misuse of medications, and indication of improved quality of life as well as return to work. Based on these findings, the requested oxycodone instant release 20 milligrams #150 is not medically necessary.