

Case Number:	CM14-0026591		
Date Assigned:	06/13/2014	Date of Injury:	02/14/2000
Decision Date:	07/16/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/03/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, 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 patient is a 60 year old male with an injury date of 02/14/2000. Based on the 02/04/14 progress report provided by [REDACTED], the patient complains of pain in his right middle back, lower back, and left hip. He describes his pain as sharp, tingling, electrical, pressure, burning, and dull. The patient also has intermittent headaches. His diagnoses include the following: 1. Lumbar spine strain/sprain. 2. Lumbar spine/bilateral lower extremity radiculopathy. 3. Lumbar spine status post spinal cord stimulator implantation. 4. Left shoulder strain/sprain. 5. Left shoulder status post arthroscopy. 6. Right shoulder strain/sprain. 7. Right shoulder status post arthroscopy. 8. Chronic opioid dependence. [REDACTED] is requesting for one prescription of Oxycodone 10 mg #150. The patient is also taking Fentanyl Patch, Tizanidine, Cymbalta, Abilify, Lyrica, Clonidine, Hydrochlorothiazide, Diovan, Trazodone, and Requip HCL. The utilization review determination being challenged is dated 02/25/14. [REDACTED] is the requesting provider, and he provided treatment reports from 01/09/14- 02/27/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PRESCRIPTION OF OXYCODONE 10 MG #150: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 88,89.

Decision rationale: According to the 02/04/14 report by [REDACTED], the patient presents with pain in his right middle back, lower back, and left hip. The request is for one prescription of Oxycodone 10 mg #150. For chronic opiate use, the MTUS Guidelines pages 88 and 89 require functioning documentation using a numerical scale or a validated instrument at least once every six months. Documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior) are required. Furthermore under outcome measure, it also recommends documentation of current pain, average pain, least pain, time it takes for medication to work, duration of pain relief with medication, etc. There are no discussions regarding any functional improvement specific to the opiate use, nor do any of the reports discuss any significant change in ADLs. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should now slowly be weaned as outlined in MTUS Guidelines. The requested Oxycodone 10 mg is a decrease from the 15 mg that the patient was initially taken. Recommendation is for authorization. The request for One Prescription of Oxycodone 10mg #150 is medically necessary and appropriate.