

Case Number:	CM14-0043730		
Date Assigned:	07/02/2014	Date of Injury:	02/20/2007
Decision Date:	08/22/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	04/10/2014

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 62-year-old male who reported an injury on 02/20/2007. The mechanism of injury was not provided within the clinical medical records. The clinical note dated 03/03/2014 indicated diagnoses of right knee osteoarthritis status post total knee replacement, left knee severe osteoarthritis, left hip severe osteoarthritis, low back pain with radicular pain, and history of GI bleed. The injured worker reported back pain with bad left sciatica. The injured worker reported he continued to use Roxicodone 30 mg 4 times a day for pain control due to the severity of the pain. On physical examination, the injured worker had limited range of motion to both hips and there was tenderness with the left hip when doing range of motion. The injured worker had reduced range of motion with the left knee with tenderness with range of motion and mild edema and there was tenderness to palpation with reduced range of motion to the injured worker's back. The injured worker's sensory was decreased in both legs. The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen included Roxicodone, Protonix, Ultram, and Sentra. The provider submitted a request for Roxicodone. A request for authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Roxicodone 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80.

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

Decision rationale: The request for Roxycodone 20mg #120 is not medically necessary. The California MTUS Guidelines state Roxycodone is a short-acting opioid, which is an effective method in controlling chronic, intermittent or breakthrough pain. The guidelines recognize four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use behaviors and side effects. Moreover, it was not indicated if the injured worker had a pain contract. In addition, it was not indicated how long the injured worker had been utilizing this medication. Moreover, the request did not indicate a frequency for the medication. Therefore, the request is not medically necessary.