

Case Number:	CM14-0061739		
Date Assigned:	07/09/2014	Date of Injury:	10/04/2007
Decision Date:	08/29/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	05/02/2014

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 Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 63-year-old male who reported an injury on 10/04/2007. The mechanism of injury was not provided. On 06/25/2014 the injured worker presented with complaints of left knee pain. Upon examination there was a varus alignment correctable to neutral and denied any lateral joint line pain. There was tenderness along the medial joint line with no patellofemoral pain. An x-ray of the left knee revealed advanced medial compartment arthritis and lateral periarticular osteophytes. The diagnosis was medial compartment arthritis. Current medications included oxycodone and OxyContin. The provider recommended oxycodone and OxyContin, the provider's rationale was not provided. The Request for Authorization Form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

OxyContin 80 mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 86.

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

Decision rationale: The request for OxyContin 80 mg with a quantity of 120 is non-certified. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse behavior, and side effects. Additionally, the injured worker's morphine equivalent exceeds the guideline recommendation of 120 mg/day. As such, the request is non-certified.

Oxycodone 30 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 86.

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

Decision rationale: The request for oxycodone 30 mg with a quantity of 90 is non-certified. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse behavior, and side effects. Additionally, the injured worker's morphine equivalent exceeds the guideline recommendation of 120 mg/day. As such, the request is non-certified.