

Case Number:	CM14-0068605		
Date Assigned:	07/14/2014	Date of Injury:	08/02/2012
Decision Date:	09/10/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/13/2014

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 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 45-year-old male who reported an injury on 08/02/2012. The injury reported was when the injured worker was carrying beams and was struck in the head. The previous treatments included acupuncture, medication, physical therapy, and massage. The diagnostic imaging included x-rays, MRI, and EMG. Within the clinical note dated 06/30/2014 it was reported the injured worker complained of neck, back, shoulder and upper extremity pain. The injured worker reported low back pain with radiation into both lower extremities. Upon the physical examination the provider noted, the injured worker had severe spasms palpable left lumbar paraspinous musculature and right lower thoracic musculature. The range of motion in the lumbar spine was flexion at 30 degrees and extension at 5 degrees. Upon examination of the shoulder, the provider noted the range of motion of the left shoulder was limited in abduction at 75 degrees. The provider indicated the injured worker had tenderness to palpation of the left lower anterior chest wall. The injured worker had tenderness to palpation over the medial and lateral epicondyles, tenderness to palpation over the proximal forearm. The provider indicated the injured worker had a negative Tinel's at the elbow and wrist. The provider requested Oxycodone HCL. However, the Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone HCL IR 5mg tablet 1/2 to 1 tab twice daily for pain #60 MDD/27 mg/24 hours:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 91.

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

Decision rationale: The request for Oxycodone HCL IR 5 mg tablets half a tablet to 1 tablet twice a day for pain #60 MDD/27 mg/24 hours is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidence by significant functional improvement. The injured worker has been utilizing the medication since at least 06/2014. Therefore, the request is not medically necessary.