MAXIMUS Federal Services

Case Number:	CM14-0085592		
Date Assigned:	07/23/2014	Date of Injury:	11/09/2002
Decision Date:	09/24/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/09/2014

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 Internal Medicine and is licensed to practice in North Carolina, Colorado, California and Kentucky. 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 an 81-year-old female injured on 11/09/02 due to undisclosed mechanism of injury. Diagnoses included interstitial cystitis, generalized anxiety, degenerative disc disease of the cervical spine and thoracic spine, cervical and lumbar facet arthropathy, bilateral sacroiliac joint pain, bilateral sciatica with piriformis, possible left rotator cuff tear, osteoarthritis, cervical facet syndrome, and myofascial spasms. Clinical note dated 07/25/14 indicated the injured worker presented complaining of neck pain varying day by day decreased with topical heat. The injured worker reported medications helped improve function. The injured worker rated pain 10/10. Physical examination revealed decreased cervical rotation, positive cervical facet loading, and positive tenderness to palpation at C5 through C7. Medications included oxycodone 30mg two tablets TID, Ativan 2mg every four hours, Trazadone 50mg QID, Voltaren gel 1% PRN, Celexa 60mg QD, Ambien, Benadryl, and MiraLax. The initial request for oxycodone 30mg #90 and oxycodone 30mg #180 was non-certified on 05/30/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 30mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

Decision rationale: This request represents a redundency in medication administration. As such, Oxycodone 30mg #90 is not recommended as medically necessary at this time.

Oxycodone 30mg #180: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, injured workers must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. The documentation indicates the medications help improve function but does not elaborate significantly. The injured worker's age and length of opioid use must be considered as aburpt cessation could pose a significant risk to the overall health of the injured worker. As such, Oxycodone 30mg #180 is recommended as medically necessary at this time.