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| Case Number: | CM14-0087657 | | |
| Date Assigned: | 07/23/2014 | Date of Injury: | 09/17/2008 |
| Decision Date: | 09/26/2014 | UR Denial Date: | 05/29/2014 |
| Priority: | Standard | Application Received: | 06/10/2014 |

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 Internal Medicine 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 44 year old male who was injured on 09/17/2008. Mechanism of injury is unknown. Prior treatment history has included the following medications: Roxicodone, Baclofen, Neurontin, Prozac, and Ambien. Progress note dated 05/23/2014 documented the patient with complaints of pain in the head, left arm, neck, left shoulder and left elbow. The frequency of his pain is worsening and there is a change since the last visit. The pain is stated to be spasticity, sharp, aching, stabbing, throbbing, dull, and burning. It is made worse by lifting, sitting, stress, standing, twisting, weather changes, cold, walking and no sleep. It is made better with heat, rest, and medication, changing positions. In the last month with medication the patient states the least pain is 4/10, average pain is 5/10 and the worst pain is 7/10. In the last month without medications the less pain is 5/10, average pain 6/10 and worst pain 8/10. Diagnosis: 1) Displacement of intervertebral disc without myelopathy of the cervical spine. 2) Spondylosis cervical 3) Cervicalgia 4) Shoulder pain 5) Joint pain in forearm 6) Epicondylitis 7) Muscle spasm. 8) Depression. Treatment Plan: Refilled medications and discontinued OxyContin 10 mg and replace with Oxycodone for BTP. We titrate Neurontin as well, would rotate to Topamax if needed. Utilization report dated 05/29/2014 did not certify the request for retrospective OxyContin 10 mg 1 tab by mouth #90 and retrospective (DOS 4/29/14): Roxicodone 15mg, #180 refill: 0 as there was no documentation provided showing the mechanism of injury that would require long term opioid therapy, neuropathic injury or use of Baclofen. Therefore, the request was deemed not medically necessary. Objective findings on examination reveal taut bands and pain on palpation at maximal point of tenderness along the twitch response at left upper trapezius and bilateral splenius capitus muscles where TPIs were administered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (DOS 4/29/14): Roxicodone 15mg, #180 refill: 0: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Oxycodone immediate release; weaning of medications Page(s): 78-80, 92, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone Page(s): 92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pian chapter, Oxycodone.

Decision rationale: The guidelines recommend chronic opioid therapy for patients who receive adequate analgesia, have no adverse effects, show no aberrant behavior, and have improvement in ADLs. The clinical documents provided did not adequately discuss the above components of chronic opioid use. There was insufficient discussion of any history of aberrant behavior or improvement in ADLs. It is unclear how long the patient has been on opioid therapy and if a pain contract is present. The patient does not appear to be obtaining significant analgesic relief from opioid therapy. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

Retrospective (DOS 4/29/14): Oxycontin 10mg, #90 refill: 0: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone controlled release Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone Page(s): 92.

Decision rationale: The guidelines recommend chronic opioid therapy for patients who receive adequate analgesia, have no adverse effects, show no aberrant behavior, and have improvement in ADLs. The clinical documents provided did not adequately discuss the above components of chronic opioid use. There was insufficient discussion of any history of aberrant behavior or improvement in ADLs. It is unclear how long the patient has been on opioid therapy and if a pain contract is present. The patient does not appear to be obtaining significant analgesic relief from opioid therapy. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.