

<b>Case Number:</b>	CM14-0097826		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	11/30/1993
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	06/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2014

### 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 Nevada. 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 records presented for review indicate that this 77 year-old individual was reportedly injured on 11/30/1993. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated 4/29/2014 indicates that there are ongoing complaints of neck pain rating down both shoulders, as well as low back pain radiates down bilateral lower extremities. The physical examination demonstrated: patient uses a cane to assist in ambulation. Left shoulder range of motion was decreased in all planes of movement. Cervical spine range of motion was decreased on flexion/extension. Positive tenderness to cervical extensors. Lumbar spine range of motion was decreased on flexion/extension. Straight leg raise was positive on the right 60 degrees. he reason diagnostic studies were available for review. Previous treatment includes medications, and conservative treatment. A request had been made for Oxycodone 15 mg #180 and was not certified in the pre-authorization process on 6/10/214.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone HCL 15mg, #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation <http://www.odg-twc.com/odgtwc/pain.htm#Weaningopioids>.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93.

**Decision rationale:** The MTUS guidelines support short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no clinical documentation of improvement in their pain and minimal increase in function with the current regimen. As such, this request is not considered medically necessary.