

Case Number:	CM15-0002791		
Date Assigned:	01/13/2015	Date of Injury:	07/28/2009
Decision Date:	03/30/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/06/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 49-year-old male who reported an injury on 07/28/2009. The mechanism of injury was not specifically stated. The injured worker is currently diagnosed with unspecified neuralgia, neuritis, and radiculitis, lumbosacral disc degeneration, and lumbar post laminectomy syndrome. On 12/22/2014, the injured worker presented for a followup evaluation. It was noted that the injured worker continued to do well and work full time on 3 oxycodone tablets per day. It was noted that the injured worker had been previously treated with a right trochanteric bursal injection on 06/28/2010 and 09/24/2010. Upon examination, there was decreased range of motion of the lumbar spine. Treatment recommendations included continuation of the current medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone-Acetaminophen 10/325mg Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-83, 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. It is noted that the injured worker has continuously utilized the above medication since at least 07/2014. Although it is noted that the injured worker reported an improvement in symptoms, there was no objective evidence of an improvement in function. Additionally, previous urine toxicology reports documenting evidence of patient compliance and nonaberrant behavior were not provided. There was also no mention of a failure of nonopioid analgesics. Furthermore, there was no frequency listed in the request. Given the above, the request is not medically appropriate.