

Case Number:	CM15-0006639		
Date Assigned:	01/26/2015	Date of Injury:	04/16/1986
Decision Date:	03/13/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/12/2015

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: New York, Pennsylvania, Washington
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

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 woman with a date of injury of 4/16/86. She was seen by her provider on 12/2/14 with complaints of back pain with radiation to the left hip and buttock. Her symptoms were relieved with rest, medications, lying down, heat and ice. Her exam showed moderate tenderness in the lumbar paraspinal muscles and L3-5 spinous processes. The straight leg raise was negative bilaterally and facet load test was positive bilaterally. Her diagnoses were back pain, lumbar spondylosis without myelopathy, subacromial impingement syndrome, joint pain-shoulder, strain or tear of rotator cuff tendon (right) and obesity. At issue in this review is the request for oxycodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-80.

Decision rationale: This injured worker has chronic back and leg pain with an injury sustained in 1986. Per the guidelines, in opiod use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The MD visit of 12/14 fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to oxycodone to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of oxycodone is not substantiated in the records.