

Case Number:	CM15-0143749		
Date Assigned:	08/04/2015	Date of Injury:	04/10/2001
Decision Date:	09/01/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/24/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 68-year-old female who sustained an industrial/work injury on 4-10-01. She reported an initial complaint of lower back and right foot pain. The injured worker was diagnosed as having lumbar radiculopathy, lumbar degenerative disc disease, mood disorder, and implanted hardware failure. Treatment to date includes medication and SCS (spinal cord stimulator) implant with removal. Currently, the injured worker complained of low back pain with radiation down the right leg. Pain was rated 3.5 out of 10 with medication and 10 out of 10 without. Per the primary physician's report (PR-2) on 4-23-15, exam noted lumbar asymmetry, loss of normal lordosis, knee jerk was slightly reduced on the left side and ankle jerk was absent on the left, motor strength of 4 out of 5, sensation was decreased over the lateral foot, medial foot, and posterior thigh on the left. The requested treatments include Roxicodone 15mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Roxicodone 15mg quantity 150 with one refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids
Page(s): 82-92.

Decision rationale: Roxicodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Roxicodone for a yr and 6 months in combination with NSAIDS. There was no mention of Tylenol Tricyclic or weaning failure. Pain reduction due to Roxicodone alone cannot be determined. The continued use of Roxicodone is not medically necessary.