

Case Number:	CM15-0182564		
Date Assigned:	09/23/2015	Date of Injury:	08/21/1998
Decision Date:	10/28/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/16/2015

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: Massachusetts

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 42-year-old female, with a reported date of injury of 08-21-1998. The diagnoses include cervical degenerative disc disease, cervical postlaminectomy syndrome, cervical facet arthropathy, and migraine headache. Treatments and evaluation to date have included cervical spine fusion at C6-7 in 2001 and 2002, Xanax, Soma, Rizatriptan Benzoate, Oxycodone (since at least 03-2015), OxyContin, Ketamine cream, and Alprazolam. It was noted that the injured worker had previously failed Baclofen, Zanaflex, Flexeril, Robaxin, cervical epidural steroid injection, physical therapy, TENS unit, acupuncture, chiropractic treatment, Gabapentin, Daypro, Zoloft, Lodine XL, Prednisone, and Amitriptyline. The diagnostic studies to date have not been included in the medical records provided. The progress note dated 08-05-2015 indicates that the injured worker was currently stable on her pain medications. Her pain level on the day of the visit was 4 out of 10. The objective findings included cervical flexion at 30 degrees, cervical extension at 10 degrees with pain in both directions; cervical right-sided facet loading test was positive; a slow and right antalgic gait; tenderness throughout the lumbar spine; positive lumbar facet loading test; decreased right shoulder range of motion; weaker right upper extremity and hand; and positive allodynia of the right arm and hand. The injured worker's work status was indicated as disabled, not working, and retired. The progress note dated 09-03-2015 indicates that the injured worker's pain level on the day of the visit was 3 out of 10 with the use of her pain medications. She stated that she was interested in reducing her Oxycodone 15mg, and desired to attempt to wean down on this medication. It was noted that the urine drug screen on 05-15-2015 was "appropriate". The treating physician stated that the injured worker

reported continued benefit with use of her Oxy IR (Oxycodone) 15mg, which reduced her pain flare-up from 7 out of 10 back down to 4 out of 10, lasting several hours in relief. It was also noted that the urine drug screen on 05-19-2015 was "appropriate". It was documented that an electrodiagnostic study in 2002 diagnosed the injured worker with reflex sympathetic dystrophy of the right upper extremity. The injured worker continued to complain of allodynia throughout the right upper extremity with the right hand being constantly cold as well as intermittent periods of swelling and splotching in the right upper extremity. She stated that since the use of Ketamine cream her symptoms had gotten much better. The objective findings include cervical flexion at 30 degrees, cervical extension at 10 degrees with pain in both directions; cervical right-sided facet loading test was positive; a slow and right antalgic gait; tenderness throughout the lumbar spine; positive lumbar facet loading test; decreased right shoulder range of motion; weaker right upper extremity and hand; and positive allodynia of the right arm and hand; the right upper extremity was held limply on her lap; and eight cold tips of the hands. It was noted that the injured worker was disabled and not working. The treatment plan included the continuation of the injured worker's medication regimen for chronic pain. There was documentation that the injured worker was stable on her current regimen, which helped her daily function, and without adverse side effects. There were no signs of overmedication, sedation, or withdrawal. The request for authorization was dated 09-09-2015. The treating physician requested Oxycodone 10mg #90. On 09-15-2015, Utilization Review (UR) modified the request for Oxycodone 10mg #90 to Oxycodone 10mg #60.

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 Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, dosing, Weaning of Medications.

Decision rationale: The claimant has a remote history of a work injury in August 1998 and underwent cervical spine fusions in 2001 and 2002. She has chronic pain including a diagnosis of right upper extremity CRPS. When seen, she had been able to decrease use of OxyContin to 30 mg three times per day but had not tolerated further reduction due to end of dose failure. Pain with medications was rated at 3/10. She wanted to try to reduce her Oxycodone dosing. Physical examination findings included pain with cervical spine range of motion. There was lumbar tenderness. Cervical and lumbar facet loading was positive. There was decreased shoulder range of motion. There were findings of right upper extremity CRPS. OxyContin and Oxycodone were prescribed. Oxycodone was changed from 15 mg #60 to 10 mg #90. The total MED (morphine equivalent dose) remained the same at 180 mg per day. Guidelines recommend against opioid dosing is in excess of 120 mg oral morphine equivalents per day. In this case, the total MED being prescribed is 1.5 times that recommended. Although the claimant has chronic pain and the use of opioid medication may be appropriate, there are no unique features of this case that would support dosing at this level, and weaning of the currently prescribed medications with a

reduction in dose was not being actively done. Ongoing prescribing at this dose is not considered medically necessary.