

Case Number:	CM15-0021213		
Date Assigned:	02/10/2015	Date of Injury:	08/03/2009
Decision Date:	03/30/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	02/03/2015

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

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:

This 58 year old male sustained an industrial injury on 8/13/09, with subsequent ongoing lumbar spine pain. Current diagnoses included lumbar degenerative disc disease, lumbar radiculopathy and lumbar disc herniation. In a PR-2 dated 12/22/14, the injured worker reported that the current regimen was not adequately controlling his pain. The injured worker complained of persistent and severe pain mainly down the left lower extremity. Physical exam was remarkable for lumbar spine with tenderness along the paraspinal musculature and left buttock region with limited range of motion, positive straight leg raise and facet loading on the left, intact motor strength in upper extremities and lower extremities. The physician noted that review of magnetic resonance imaging lumbar spine suggested that an annular tear could be causing symptoms. The treatment plan included transforaminal steroid injection to left L3-4 and L4-5, referral for possible spinal cord stimulation and continuing Oxycodone, Ambien and Crestor. The progress report indicates that the medicine helps the patient when he takes it, and that he denies side effects from the current treatment regimen. The patient attempts to use as little medication as possible. It appears in numerous treatments have been attempted recently including an epidural injection, Lyrica, suggestion of a spinal cord stimulator trial, surgical consultation, and a discogram. On 1/6/15, Utilization Review noncertified a request for Oxycodone 20 mg # 60, citing CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 20 mg # 60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 9792.26 MTUS (Effective July 18, .

Decision rationale: Regarding the request for oxycodone (Roxicodone), California Pain Medical Treatment Guidelines state that oxycodone is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's pain and causing no side effects. Additionally, the patient is using as little medication as possible. Other treatment options are being pursued. The patient is noted to have significant pain that interferes with function. It is acknowledged that there is no specific documentation of functional improvement and percent reduction in pain or reduced NRS. However, a one month supply of medication, as requested here, should allow the requesting physician to document those things. As such, the currently requested oxycodone (Roxicodone) is medically necessary.