

<b>Case Number:</b>	CM15-0022696		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	05/29/1996
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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 63-year-old male who reported injury on 05/29/1996. The mechanism of injury was not provided. The documentation indicated the injured worker had undergone CURES and was appropriate. The injured worker had utilized the medication since at least 01/2014. The injured worker underwent urine drug screens. There was a Request for Authorization submitted for review dated 09/18/2014. The documentation of 11/26/2014 revealed the injured worker had right shoulder pain that was worse. The injured worker indicated that the severity of pain without medications was 9/10. The pain was improved with medication. Other treatments included epidural steroid injections. The medications included clonazepam 0.5 mg 1 tablet twice a day, and oxycodone hydrochloride 15 mg 1 every 8 hours. Surgical history included right shoulder surgery. Other therapies included medications and trigger point injections. The physical examination revealed decreased range of motion. The diagnoses included primary localized osteoarthritis shoulder region, adhesive capsulitis of shoulder, and cervical spondylosis without myelopathy. The request was made for a refill of oxycodone hydrochloride 1 by mouth every 8 hours and a urine drug screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 20mg, #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker was being monitored for aberrant drug behavior through urine drug screens. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for oxycodone 20 mg #90 is not medically necessary.