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| Case Number: | CM15-0049659 | | |
| Date Assigned: | 03/23/2015 | Date of Injury: | 11/17/2000 |
| Decision Date: | 05/01/2015 | UR Denial Date: | 03/09/2015 |
| Priority: | Standard | Application Received: | 03/16/2015 |

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: 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 58-year-old female, with a reported date of injury of 11/17/2000. The diagnoses include cervical spondylosis, cervical post laminectomy syndrome, lumbar spondylosis, and chronic right shoulder pain. Treatments to date have included HELP (Health Education for Living with Pain) program, an x-ray of the cervical spine, oral medications, and cervical laminectomy with foraminotomies and bone grafting fusion. Currently, the injured worker currently complains of neck pain, low back pain, and right shoulder pain. The progress note dated 02/23/2015 indicates that the injured worker rated her pain 3 out of 10. She had joint stiffness, leg cramps, muscle aches, sciatica, and swollen joints. The physical examination showed decreased cervical range of motion, decreased lumbar range of motion, no sensory deficits of the lower extremities, positive right straight leg raise test, an antalgic gait, and no sensory deficits of the upper extremities. The treating physician requested Oxycodone HCL 10mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone HCL 10mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OxyContin (Oxycodone), Opioids, Weaning of Medications.

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

Decision rationale: Oxycodone 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 opioids including Oxycontin and Vicodin since at least 2003 and Oxycodone for over a year. The pain scale has been stable at 3/10 while on medications for a year. There was no indication of failure of Tylenol use for breakthrough pain or weaning attempt. The continued and chronic use of Oxycodone is not medically necessary.