

<b>Case Number:</b>	CM13-0053681		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	12/17/2011
<b>Decision Date:</b>	04/03/2014	<b>UR Denial Date:</b>	11/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of December 17, 2001. Thus far, the applicant has been treated with the following: Analgesic medications; topical compounds; attorney representation; prior right wrist ORIF surgery; multiple shoulder surgeries; unspecified amounts of physical therapy over the life of the claim; bilateral knee arthroscopy; unspecified amounts of acupuncture to date; and epidural steroid injection therapy. In a Utilization Review Report of November 6, 2013, the claims administrator denied request for immediate release oxycodone and a topical compound. The applicant's attorney subsequently appealed. In a clinical progress note of November 26, 2013, the applicant is described as having persistent shooting knee and low back pain. The applicant is status post an epidural steroid injection on February 20, 2013, status post right knee arthroscopy on July 24, 2013. The applicant followed to receive trigger point injections. The applicant reports 7/10 pain with medications and states that he is primarily chair bound without medications. The applicant states that his ability to perform self-care, grooming, and personal hygiene has been ameliorated as a result of medication usage. The applicant is hypertensive and is on Tenormin for the same. The applicant apparently had to discontinue Norco, Neurontin, and Naprosyn owing to transaminitis. OxyContin and Lidoderm patches are endorsed, along with topical compounds. An earlier note of November 5, 2013 is notable for comments that the applicant had previously utilized Norco, Neurontin, Naprosyn but was forced to discontinue the same owing to transaminitis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 MONTH SUPPLY OF OXYCODONE10MG #60: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

**Decision rationale:** As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful pain relief, successful return to work, and/or improved function effected as a result of ongoing opioid usage. In this case, the applicant is reportedly able to improve performance of activities of daily living, perform home exercises, participate in physical therapy, etc. as a result of ongoing oxycodone usage. His pain scores dropped from 9/10 to 6/10 with oxycodone usage. He apparently is unable to use Norco, Neurontin, and Naprosyn owing to issues with transaminitis. Continued usage of oxycodone immediate release is therefore indicated, for all of the stated reasons. Accordingly, the original utilization review decision is overturned. The request is certified, on Independent Medical Review.

**1 MONTH SUPPLY COMPOUNDED KETOPROFEN 15%-GABAPENTIN 10%-LIDOCAINE 10% (120 G): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

**Decision rationale:** As noted on pages 112 and 113 of the MTUS Chronic Pain Medical Treatment Guidelines, neither ketoprofen nor gabapentin is recommended for topical compound formulation purposes. Since one or more ingredients in the compound carry an unfavorable recommendation, the entire compound is considered not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Accordingly, the request is likewise not certified, on Independent Medical Review.