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| Case Number: | CM14-0130858 | | |
| Date Assigned: | 08/20/2014 | Date of Injury: | 06/29/2009 |
| Decision Date: | 09/29/2014 | UR Denial Date: | 07/23/2014 |
| Priority: | Standard | Application Received: | 08/15/2014 |

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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/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 injured worker is a 48-year-old female who reported an injury on 06/29/2009. The mechanism of injury was not provided. On 07/16/2014 the injured worker presented with complaints related to the bilateral shoulder and neck. Current medications included Abilify, Celexa, Claritin, clonazepam, cyclobenzaprine, Lidoderm, meloxicam, oxycodone, Trazadone, and Zocor. On examination of the upper extremities, there was tenderness noted over the bilateral upper trapezius, latissimus, scalene, pectorals minor and joint tenderness noted over the glenohumeral joint of the left upper extremity. There was decreased range of motion in the left upper extremity and joint swelling noted over the subacromial. The diagnosis is shoulder rotator cuff syndrome. Prior therapy included heat, physical therapy, and analgesics or anti-inflammatory medications. The provider recommended oxycodone 10 mg, the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10mg Qty: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Oxycodone Page(s): 81, 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The request for Oxycodone 10 mg Qty: 60.00 are not medically necessary. California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse behavior, and side effects. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. Therefore, the request is not medically necessary.