

<b>Case Number:</b>	CM14-0219357		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	08/01/2009
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	12/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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. 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: New York, Pennsylvania, Washington  
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

### 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 is a 46 year old male worker with a date of injury of August 1, 2009. The mechanism of injury is unknown. Diagnoses include total body pain, Valley fever, right shoulder impingement syndrome, right shoulder pain, fibromyalgia, chronic pain syndrome, chronic pain-related insomnia and neuropathic pain. On December 2, 2014, the injured worker complained of chronic whole body pain and diffuse myalgias. Regarding physical activities, he had some difficulty with standing, sitting, rising from a chair, getting into and out of bed, lifting up to 10 pounds and walking. Physical examination revealed some tenderness in the trapezius muscle groups bilaterally as well as the interscapular area. There was tenderness in the lumbosacralparaspinous muscles. Range of motion of the lumbar spine was limited due to pain. Painful range of motion was noted to the bilateral shoulders. There was tenderness about both hips, both elbows and wrists. Treatment to date has included medications. A request was made for Roxicodone 30mg #150 and Opana ER 40mg #120. On December 10, 2014, utilization review modified the request to Roxicodone 30mg #135 and Opana ER 40mg #108 citing MTUS guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Roxicodone 30mg QTY: 150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20; 9792.26 Page(s): 74-80.

**Decision rationale:** This injured worker has chronic pain with an injury sustained in 2009. The medical course has included use of several medications including narcotics. Per the guidelines, in opiod use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The MD visit of 12/14 fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to roxicodone to justify use per the guidelines. The medical necessity of roxicodone is not substantiated in the records.

**Opana ER 40mg QTY: 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 9792.26 Page(s): 74-80.

**Decision rationale:** This injured worker has chronic pain with an injury sustained in 2009. The medical course has included use of several medications including narcotics. Per the guidelines, in opiod use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The MD visit of 12/14 fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to opana ER to justify use per the guidelines. The medical necessity of opana ER is not substantiated in the records.