

<b>Case Number:</b>	CM15-0003907		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	05/23/2004
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 56-year-old female who reported an injury on 07/01/1998 due to an unspecified mechanism of injury. On 12/12/2014, she presented for a followup evaluation regarding her work related injury. She reported neck pain with radiation into the bilateral upper extremities and elbows with numbness to the hands. She also reported headaches, depression and anxiety, and gastrointestinal issues. Her medications included estradiol 0.5 mg, Linzess 290 mcg, promethazine HCl 25 mg, meloxicam 15 mg, bupropion HCl 150 mg, Oxycontin 60 mg ER 2 per day, oxycodone HCl 15 mg as needed every 4 hours, amoxicillin 500 mg and acyclovir 200 mg. A physical examination showed moderate paracervical spasm noted, moderate parathoracic myospasm noted, and decreased range of motion to the cervical spine with no swelling or deformity. Neurologic examination was nonfocal and motor strength was normal to the upper and lower extremities; sensation was intact. She was diagnosed with thoracic outlet syndrome, intervertebral disc disorder with myelopathy, myofascitis, nerve root irritation, anxiety and depression, slow transit constipation and status post cervical spine fusion. Treatment plan was for Oxycontin 15 mg number 180 and Oxycontin 60 mg number 60. The rationale for treatment was to provide the injured worker with pain relief.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 60mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 92; 78-80; 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

**Decision rationale:** According to the California MTUS Guidelines an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should be performed during opioid therapy. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding the upper back. However, there is a lack of documentation showing that she has had a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, no official urine drug screens or CURES reports were provided for review to validate her compliance with her medication regimen. Furthermore, the frequency of the medication was not provided within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

**Oxycontin 15mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 92; 78-80; 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

**Decision rationale:** According to the California MTUS Guidelines an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should be performed during opioid therapy. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding the upper back. However, there is a lack of documentation showing that she has had a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, no official urine drug screens or CURES reports were provided for review to validate her compliance with her medication regimen. Furthermore, the frequency of the medication was not provided within the request. Therefore, the request is not supported. As such, the request is not medically necessary.