

Case Number:	CM15-0004039		
Date Assigned:	01/15/2015	Date of Injury:	02/25/2002
Decision Date:	03/23/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	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 53-year-old female who reported an injury on 02/25/2002 due to an unspecified mechanism of injury. On 12/30/2014, she presented for a followup evaluation. She continued to complain of chronic pain radiating into the right arm and hand. Objective findings showed tenderness to palpation and spasm in the cervical spine, left greater than right, with negative Hoffmann's bilaterally. She had diminished sensation in the dorsal right forearm, dorsal right hand, and intact sensation otherwise to the left upper extremity. Strength was 4/5 with wrist extension and finger extension, otherwise 5/5 throughout. She was diagnosed with cervical spine degenerative disc disease, right shoulder sprain and strain, history of hypertension, diabetes, anxiety, and depression. Her medications included Norco 10/325 mg 1 every 6 hours as needed for pain, OxyContin 20 mg 1 twice a day, and Soma 250 mg one 3 times a day as needed for spasm. The treatment plan was for the purchase of hydrocodone/APAP 10/325 mg #120 and OxyContin 20 mg #60. The rationale for treatment was to treat the injured worker's symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pharmacy purchase of Hydroco/APAP 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain.

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 cervical spine and upper extremities. However, there is a lack of documentation showing that the injured worker has 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 stated within the request. Therefore, the requested medication is not supported. As such, the request is not medically necessary.

Pharmacy purchase of Oxycontin 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain.

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 cervical spine and upper extremities. However, there is a lack of documentation showing that the injured worker has 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 stated within the request. Therefore, the requested medication is not supported. As such, the request is not medically necessary.