

Case Number:	CM15-0116277		
Date Assigned:	06/24/2015	Date of Injury:	04/20/2011
Decision Date:	07/24/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/16/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 43 year old male, who sustained an industrial injury on 4/20/2011. He reported developing low back pain from routine work activities. Diagnoses include lumbar facet pain, multilevel lumbar disc herniation with annular fissure, retrolisthesis, and facet arthropathy. Treatments to date include NSAID, analgesic, opioid, epidural steroid injection, radiofrequency ablation, therapeutic injections, and physical therapy. Currently, he complained of low back pain with radiation down bilateral lower extremities. The records indicated he had been recommended for surgery, and required a follow up appointment to pursue that avenue. On 5/14/15, the physical examination documented observation of discomfort while sitting and fatigue. The provider documented multilevel lumbar disc herniations and facet arthropathy. There was significant pain with range of motion, questionable positive left side straight leg raise and tenderness with palpation. The plan of care included Oxycodone IR 10mg #180.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone IR 10mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 75-80.

Decision rationale: Regarding the request for Oxycodone (Roxicodone), Chronic Pain Medical Treatment Guidelines state that Oxycodone is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is providing moderately relief to his pain. However, there is no documentation regarding functional relief, no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Oxycodone (Roxicodone) is not medically necessary.