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| Case Number: | CM15-0126812 | | |
| Date Assigned: | 07/13/2015 | Date of Injury: | 03/14/2002 |
| Decision Date: | 09/01/2015 | UR Denial Date: | 06/08/2015 |
| Priority: | Standard | Application Received: | 06/30/2015 |

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: Arizona, Texas

Certification(s)/Specialty: Internal 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:

The injured worker is an 80 year old male who sustained an industrial injury on 3-14-02. Diagnoses are backache, degeneration of cervical intervertebral disc, displacement of lumbar intervertebral disc without myelopathy, dysthymia, low back pain, lumbar post-laminectomy syndrome, primary fibromyalgia syndrome, and spasm of muscle. In a primary treating physician's progress report and request for authorization dated 6-1-15, the physician notes the injured worker has chronic pain of the low back and both lower extremities and numbness and tingling of lower extremities. He has a history of multiple back surgeries. It is noted that medications continue to benefit by decreasing his significant pain and provide functional gains by assisting his activities of daily living, mobility, and restorative sleep. He continues toward a goal of decreasing pain medication. He reports medication reduces his 9 out of 10 pain by 30% and has no reported side effects. His spinal cord stimulator helps with radicular pain. It was re-programmed 3-18-15 and he states coverage is improved. His lumbar support is worn and no longer provides support. A replacement has been requested. He has a limp and his gait is antalgic. Exam of the lumbar spine reveals a flat back with significant muscle spasms. Active range of motion is restricted and painful. There is tenderness to palpation of the transverse process on the right and left at L4. There is tenderness to palpation of the right and left hip area. It is noted that the injured worker has a signed pain management agreement on file-updated 5-4-15 and urine drug testing is consistent with prescriptions. The treatment plan regarding medications is to refill Gabapentin, Sertraline and OxyContin. The requested treatment is Oxycontin ER 10 mg, a quantity of 130.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin ER 10 MG 130 Tabs: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-.26 Page(s): 74-96.

Decision rationale: Management of patients using opioids for chronic pain control includes ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The indication for continuing these medications include if the patient has returned to work or if the patient has improved functioning and pain. In this case, the documentation doesn't support that the patient has had a meaningful improvement in function or pain while taking this medication. The continued use is not medically necessary.