

Case Number:	CM15-0127813		
Date Assigned:	07/14/2015	Date of Injury:	11/02/2000
Decision Date:	08/13/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	07/02/2015

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 73 year old male, who sustained an industrial injury on 11/02/2000. Diagnoses include right lumbar radiculopathy, failed back surgery syndrome, left upper parathoracic facet arthropathy, chronic thoracic compression fracture, left upper thoracic myofascial pain syndrome, left cervical radiculopathy and cervical degenerative disc disease. Treatment to date has included surgical intervention and conservative measures including diagnostics, narcotic pain medication, home exercise, spinal cord stimulator, heat and cold application and rest. Per the Primary Treating Physician's Progress Report dated 6/05/2015, the injured worker reported continuation of lower back pain rated as 8/10 in intensity. Physical examination of the lumbar spine revealed diffuse tenderness. Forward flexion was 70 degrees and hyperextension was 10 degrees. The plan of care included opioid pain medications and authorization was requested for Oxycodone 10mg #150.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone Hydrochloride 10mg quantity 150, 1 by mouth every four to six hours as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-92; 78-80; 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 44, 47, 75-79, 120.

Decision rationale: Regarding the request for oxycodone, California Pain Medical Treatment Guidelines state that this 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 no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS) and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. In light of the above issues, the currently requested oxycodone is not medically necessary.