

<b>Case Number:</b>	CM13-0002308		
<b>Date Assigned:</b>	01/10/2014	<b>Date of Injury:</b>	12/06/2001
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	07/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2013

### 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. The expert reviewer is Board Certified in Internal Medicine and Emergency Medicine, and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 59-year-old with a date of injury of December 6, 2001. A progress report associated with the request for services, dated June 20, 2013, identified subjective complaints of pain in the left elbow, right hand, and both wrists. Objective findings included swelling and decreased range-of-motion of the left elbow. There was tenderness to palpation and decreased range-of-motion of the right wrist. The right hand was tender and swollen. Diagnoses included wrist, elbow, and hand pain. Treatment has included opioid therapy for over one year. This patient stated his medications were working well. This patient has also received psychotherapy and acupuncture. This patient noted that he re took some old trazadone in order to sleep. A Utilization Review determination was rendered on July 9, 2013 recommending non-certification of "1 prescription of oxycodone hci 15 mg #112 and 1 prescription of oxycontin 40mg #90".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**THE REQUEST FOR 1 PRESCRIPTION OF OXYCODONE HCI 15 MG #112:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 74-83.

**Decision rationale:** The patient is on oxycodone. This is classified as an opioid analgesic. The California Medical Treatment Utilization Schedule (MTUS) Guidelines related to on-going treatment of opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity (Eriksen 2006). The documentation submitted lacked a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. The Guidelines also state that with chronic low back pain, opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (greater than sixteen weeks), but also appears limited." The patient has been on opioids well in excess of sixteen weeks. In this case, there is no documentation of the elements of the pain assessment referenced above for necessity of therapy beyond 16 weeks, where the evidence is otherwise unclear. Additionally, a pathologic diagnosis for the patient's joint pain was not listed. The request for one prescription of oxycodone HCL 15mg, 112 count, is not medically necessary or appropriate.

**THE REQUEST FOR 1 PRESCRIPTION OF OXYCONTIN 40MG #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-83.

**Decision rationale:** Oxycontin is an extended release form of oxycodone. This is classified as an opioid analgesic. The California Medical Treatment Utilization Schedule (MTUS) Guidelines related to on-going treatment of opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity (Eriksen 2006). The documentation submitted lacked a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. The Guidelines also state that with chronic low back pain, opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (greater than sixteen weeks), but also appears limited." The patient has been on opioids well in excess of sixteen weeks. In this case, there is no documentation of the elements of the pain assessment referenced above for necessity of therapy beyond sixteen weeks, where the evidence is otherwise unclear. Additionally, a pathologic diagnosis for the patient's joint pain was not listed.

