

<b>Case Number:</b>	CM13-0012906		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	07/18/2007
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	08/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2013

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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:

The injured worker is a 56-year-old male who reported an injury on 07/18/2007, the mechanism of injury was not provided. The clinical note dated 03/07/2013 noted the injured worker presented with complaints of increased back and bilateral leg pain. He stated that there was burning pain down the back of the bilateral legs into his feet and back pain across the lower back is aching and throbbing. There was increased bilateral spasm and activities involving bending, stooping, climbing, twisting and turning aggravate the pain. Past treatment included medication for gastroesophageal reflux disease (GERD), hypertension, asthma, and elevated lipids. On examination, there was a positive straight leg raise, decreased sensation L4-5 and L5-S1 dermatomes, tenderness upon palpation of the bilateral lumbar spine, range of motion restricted to 50% of normal in both anterior/posterior (AP) and lateral planes. The diagnoses were lumbar discogenic disease, lumbar facet syndrome, lumbar radiculitis, and status post bilateral carpal tunnel release. The provider is considering epidural steroid injections, and recommending pharmacy purchase of APAP/Oxycodone 325 mg with a quantity of 120. The request for authorization form and the provider's rationale is not included in the medical documents.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHARMACY PURCHASE OF APAP/OXYCODONE TAB 325MG-10MG, #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 Opioids, Criteria for use Page(s): 78.

**Decision rationale:** The request for pharmacy purchase of APAP/Oxycodone tab 325/10 mg, #120 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic low back pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse behavior, and side effects. The request as submitted failed to provide the frequency of the medication. As such, the request is not medically necessary.