

<b>Case Number:</b>	CM14-0100376		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	07/28/2009
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 48-year-old male who reported an injury on 07/28/2009. The mechanism of injury was not provided within the documents reviewed. The injured worker's diagnoses were noted to be lumbosacral disc disease and lumbar radiculopathy. Prior treatment was listed as medications. Pertinent surgical history was noted to be right trochanteric bursa injection. A clinical evaluation on 06/10/2014 noted the injured worker to have subjective complaints of low back pain. The objective physical exam findings were noted to be decreased range of motion for flexion and extension of the lumbar spine. Medications were noted to be oxycodone-acetaminophen. The treatment plan indicated medication refills and a return visit. The rationale for the request was provided within the treatment plan of the clinical evaluation. A Request for Authorization dated 04/01/2014 was provided with the documents submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone-Acetaminophen 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines When to Continue Opioids and Opioids for Neuropathic Pain Page(s): 80-83.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid On-Going Management Page(s): 78.

**Decision rationale:** The request for Oxycodone-Acetaminophen 10/325mg quantity 90 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines identify 4 domains that are relevant for ongoing monitoring of chronic pain patients on opiates: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The Pain assessment should include current pain level, the least reported pain over the period since the last assessment, average pain level, intensity of pain after taking the opiate, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be demonstrated by the patient's decreased pain, increased level of function, or improved quality of life. The documentation submitted for review provides an inadequate pain assessment, lacking the necessary information described above. In addition, the request fails to include a dosage frequency. Therefore, the request for Oxycodone-Acetaminophen 10/325mg quantity 90 is not medically necessary or appropriate.