

<b>Case Number:</b>	CM14-0024893		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	07/14/1989
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2014

### 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 Anesthesiology, has a subspecialty in Pain 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:

The injured worker is a 66-year-old female who reported an injury on 07/14/1989. The mechanism of injury was not provided for the clinical review. The diagnoses included cervical region post laminectomy syndrome, depression and lumbar herniated nucleus pulposus. The treatments included surgery, medications and MRI and TENS, as well as acupuncture, aquatic therapy and epidural injections. Per the clinical note dated 01/06/2014, it was reported that the injured worker complained of neck and back pain. On the physical examination, the provider noted limited shoulder range of motion. The provider noted that the injured worker had decreased sensation of the right thumb. The patient had a positive straight leg raise test on the left. The provider noted that the injured worker had decreased sensation to the distal lower extremity. The request submitted is for Oxycodone IR. However, the rationale was not provided for the clinical review. The request for authorization was submitted and dated on 01/06/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **OXYCODONE IR 20MG TABLETS, #180 (FOR SYMPTOMS RELATED TO CERVICAL AND LUMBAR SPINE INJURY): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Goodman Gilman's The Pharmacological Basis of Therapeutics, 12th ed. McGraw Hill, 2006, and Non-MTUS website Physician's Desk Reference, 68th ed. www.RxList.com. Non-MTUS website ODG Workers Compensation Drug

Formulary, [www.odg-twc.com/odgtwc/formulary.htm](http://www.odg-twc.com/odgtwc/formulary.htm) and Non-MTUS website [drugs.com](http://drugs.com) and Non-MTUS website [Epocrates Online, www.online.epocrates.com](http://www.online.epocrates.com) and Non-MTUS website [Monthly Prescribing Reference, www.empr.com](http://www.empr.com) and Non-MTUS website [AMDD Agency Medical Directors' Group Dose Calculator, www.agencymeddirectors.](http://www.amdd.org)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids, criteria for use, On-Going Management page(s) 78.

**Decision rationale:** The injured worker complained of neck and back pain. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. The injured worker has been utilizing the medication since at least 11/2013. There was a lack of documentation indicating that the medication had been providing an objective functional benefit and improvement. The request as submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.