

<b>Case Number:</b>	CM14-0058610		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	02/26/2000
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	04/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2014

### 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 and Rehabilitation and is licensed to practice in California. 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 records presented for review indicate that this 57 year-old individual was reportedly injured on 2/26/2000. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated 3/25/2014, indicates that there are ongoing complaints of chronic low back pain. The physical examination demonstrated neurologic: D10 reflexes the upper and lower extremities are decreased equal. Cervical spine: positive tenderness to palpation paraspinal muscles. Thoracic exam unremarkable. Lumbar spine: positive tenderness to palpation lumbar paraspinal muscles. Limited range of motion. Positive straight leg raise bilaterally. Antalgic gait. Decreased left upper extremity, left lower extremity and right lower extremity muscle strength. Sensory exam: decreased sensation a light touch right, L5, and S1. Decreased sincerity light touch left C-5, C6, C7, L5, and S1. No reason diagnostic studies are available for review. Previous treatment includes previous lumbar laminectomy, medication, and conservative treatment. A request had been made for Oxycodone 30 mg #90 and was not certified in the pre-authorization process on 4/25/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone Hcl 30mg one p.o TID as needed #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines The Expert Reviewer based his/her decision on the MTUS pages 74, 78, 93 of 127 Page(s): 74, 78, 93 of 127.

**Decision rationale:** MTUS guidelines support short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic low back pain that is currently rated 7/10 on the visual analog scale today. After reviewing the medical documentation provided it is noted the claimant is taking a morphine equivalent dosage that is significantly higher than the maximum recommended dosage. Patient's pain is not optimally controlled at this time. As such, the current regimen pain medication is suboptimal. Therefore, this request is not considered medically necessary.