

<b>Case Number:</b>	CM14-0190107		
<b>Date Assigned:</b>	11/21/2014	<b>Date of Injury:</b>	12/17/1994
<b>Decision Date:</b>	01/09/2015	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2014

### 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 Management 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:

This is a 58 year old female who sustained a work related injury on 12/17/1994. She was cleaning a house, picked up a vacuum cleaner from a closet and began having low back, hip and thoracic pain. She also reported repetitive bending, twisting and lifting. Per the Primary Treating Physician's First Examination dated 10/07/2014 the injured worker reported persistent low back pain radiating to the lower thoracic region and in the shoulder blade region. She has received conservative treatment including physical therapy, chiropractic treatment, injections and medication management. She underwent a lumbar fusion in 1998. Physical examination revealed spasms in the lumbar paraspinal muscles and stiffness in the lumbar spine. There was tenderness in the lumbar facet joints bilaterally, worse on the left. Lumbar spine forward flexion was 20 degrees and extension 5 degrees. Extension increases low back pain. Tenderness was noted at bilateral posterior superior iliac spine and bilateral hip joint, worse on the right side. Right hip rotation aggravates leg pain. Patrick test was positive. Diagnoses included lumbar radiculopathy, lumbar facetal pain, bilateral hip pain, sacroiliitis, thoracic pain and neck pain. The plan of care included pain medication. She continues to work full time in a sedentary position. On 10/21/2014, Utilization Review non-certified a prescription for Oxycontin 40 mg, 150 count, Oxycontin 20 mg, thirty count and Norco 10/325 mg, 120 count based on lack of medical necessity. The MTUS Chronic Pain Medical Treatment Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 40 mg, 150 count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone Page(s): 74-80;92. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycontin. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of Oxycontin. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculopathy, lumbar facetal pain, bilateral hip pain, sacroiliitis, thoracic pain and neck pain. However, there is no documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. In addition, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Furthermore, given documentation of ongoing treatment with Oxycontin, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Oxycontin use to date. Therefore, based on guidelines and a review of the evidence, the request for Oxycontin 40 mg, 150 count is not medically necessary.

**Oxycontin 20 mg, thirty count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone Page(s): 74-80;92. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycontin. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies

documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of Oxycontin. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculopathy, lumbar facetal pain, bilateral hip pain, sacroiliitis, thoracic pain and neck pain. However, there is no documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. In addition, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Furthermore, given documentation of ongoing treatment with Oxycontin, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Oxycontin use to date. Therefore, based on guidelines and a review of the evidence, the request for Oxycontin 20 mg, thirty count is not medically necessary.

**Norco 10/325 mg, 120 count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculopathy, lumbar facetal pain, bilateral hip pain, sacroiliitis, thoracic pain and neck pain. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with Norco, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325 mg, 120 count is not medically necessary.