

<b>Case Number:</b>	CM15-0136750		
<b>Date Assigned:</b>	07/24/2015	<b>Date of Injury:</b>	07/24/1995
<b>Decision Date:</b>	09/28/2015	<b>UR Denial Date:</b>	06/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Family Practice

### 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 52 year old male, who sustained an industrial injury on 07/24/1995. The injured worker is currently temporarily totally disabled. The injured worker is currently diagnosed as having left shoulder sprain/strain, bilateral carpal tunnel syndrome, cervical herniated nucleus pulposus with stenosis, lumbar herniated nucleus pulposus, right knee internal derangement, status post left ankle fracture, status post morphine pump, status post anterior cervical discectomy and fusion with removal of hardware, status post cervical decompression and fusion, gastroesophageal reflux disease secondary to medicine usage, L1 compression fracture, and status post fall on 01/06/2011 secondary to right knee weakness. Treatment and diagnostics to date has included home exercise program and medications. In a progress note dated 06/04/2015, the injured worker presented with complaints of multiple pain sites, currently rated 0/10 on the pain scale. The physician noted that the injured worker's average pain level is 10/10 without medications, 0/10 with medications at rest, and 9/10 with medications with light activity. Objective findings include decreased deep tendon reflexes in the upper and lower extremities but equal, cervical and lumbar spine tenderness, and positive bilateral straight leg raise test. The treating physician reported requesting authorization for Oxycodone and Medrol (Pak).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone HCL 15mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-82.

**Decision rationale:** This patient receives treatment for chronic pain involving the low back, neck, and R knee. This relates back to a work injury dated 07/24/1995. This review addresses a request for Oxycodone 15mg, #120. The patient also has had a morphine pump. The medical diagnoses include post laminectomy syndrome cervical spine and lumbar spine. On exam there is tenderness to palpation of the lumbar facet joints. Lumbar flexion is reduced to 35 degrees. Power is reduced in all four limbs. This patient has become opioid dependent, exhibits opioid tolerance, and may be exhibiting hyperalgesia, which are all associated with long-term opioid treatment. Opioids are not recommended for the long-term management of chronic pain, because clinical studies fail to show either adequate pain control or a return to function, when treatment relies on opioid therapy. The documentation fails to document any quantitative assessment of return to function while taking the medication, which is an important clinical measure of drug effectiveness. Based on the documentation treatment with oxycodone is not medically necessary.

**Medrol (pak) 4mg #1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Oral Corticosteroids.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, Corticosteroids.

**Decision rationale:** This patient receives treatment for chronic pain involving the low back, neck, and R knee. This relates back to a work injury dated 07/24/1995. This review addresses a request for Medrol dose pack. The patient also has had a morphine pump. The medical diagnoses include post laminectomy syndrome cervical spine and lumbar spine. On exam, there is tenderness to palpation of the lumbar facet joints. Lumbar flexion is reduced to 35 degrees. Power is reduced in all four limbs. Medrol is medroxyprogesterone, an oral corticosteroid. The ODG treatment guidelines for low back pain do not recommend using corticosteroids to treat chronic pain. They state that there is no data on the efficacy or safety when using corticosteroids on patients with chronic pain. Given the potential adverse side effects with these medications, they should be avoided. Medrol is not medically necessary.