

<b>Case Number:</b>	CM15-0059788		
<b>Date Assigned:</b>	04/06/2015	<b>Date of Injury:</b>	11/08/2009
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/30/2015

### 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: New Jersey

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 49 year old male who sustained an industrial injury on 11/8/09. The mechanism of injury is unclear. Since the injury, he has had MRI, computed tomography, pain x-rays and epidural steroid injections (locations and dates not specified). Currently he complains of achy pain in the low back, hips and legs. Intensity of pain without medications is 8/10. Medications improve pain and activity aggravates the pain. Medication duration is 3-4 hours. His laboratory evaluations are appropriate for prescribed medications. His medications are gabapentin, oxycodone. Diagnoses include lumbar spondylosis without myelopathy; lumbar radiculopathy; degenerative lumbar disc; muscle spasms. Treatments noted were medications. In the progress note dated 3/6/15, the treating provider's plan of care requests refill of oxycodone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 20mg, #120:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines When to Discontinue Opioids; Opioids for chronic pain; Opioids, dosing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 78-96.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that opioids may be considered for moderate to severe chronic pain as a secondary treatment, but require that for continued opioid use, there is to be ongoing review and documentation of pain relief, functional status, appropriate medication use with implementation of a signed opioid contract, drug screening (when appropriate), review of non-opioid means of pain control, using the lowest possible dose, making sure prescriptions are from a single practitioner and pharmacy, and side effects, as well as consultation with pain specialist if after 3 months unsuccessful with opioid use, all in order to improve function as criteria necessary to support the medical necessity of opioids. Long-term use and continuation of opioids requires this comprehensive review with documentation to justify continuation. In the case of this worker, there was a report of no side effects, modest, but significant functional gains (ability to walk about and leave house more often) with the ongoing use of oxycodone, and pain reduction. Therefore, it seems reasonable to support the continued use of oxycodone 20 mg, and the request for an additional 120 pills is medically necessary.