

<b>Case Number:</b>	CM14-0147625		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	10/17/2009
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2014

### 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 Tennessee. 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 case involves a 56-year-old male with a 10/17/09 date of injury. The mechanism of injury occurred as a result of a lifting injury. According to a report dated 8/15/14, the patient complained of intermittent radicular symptoms overlap with low back pain, despite pain relief from an epidural steroid injection on 5/9/14. He stated that he was trying to be as active as he can, but when he does he pays for it for the next few days and was unable to move. Objective findings include antalgic gait, restricted lumbar spine range of motion, lumbar extension positive with left radicular symptoms in the S1 distribution, and manual muscle testing grossly 5/5. Diagnostic impressions include lumbosacral radiculitis, lumbar post-laminectomy syndrome, and spinal stenosis of lumbar region, psychalgia, depressive disorder, and anxiety. Treatments to date are medication management, activity modification, surgery, and epidural steroid injections (ESI). A UR decision dated 8/26/14 denied the requests for Oxycodone 10mg 90 tablets between 8/20/14 and 10/4/14 and Oxycodone 10mg 90 tablets between 9/15/14 and 10/4/14. The patient's response to its prior use was not discussed in the most recent report in terms of measured degree of pain relief afforded and evidence of functional improvement.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 10mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. Guidelines do not support the continued use of opioid medications without documentation of functional improvement. In addition, there is no documentation of an opioid pain contract or CURES monitoring. Therefore, the request for Oxycodone 10mg #90 was not medically necessary.

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