

<b>Case Number:</b>	CM14-0167848		
<b>Date Assigned:</b>	10/15/2014	<b>Date of Injury:</b>	01/05/2005
<b>Decision Date:</b>	11/18/2014	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2014

### 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 Neuromusculoskeletal Medicine and is licensed to practice in Arizona. 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 patient is a 58-year-old male who sustained a work related injury on 01/05/2005 as a result of an unknown mechanism of injury. Since then he has complained of back pain that radiates to the left hip with associated left sciatic symptoms requiring a cane for ambulation. He is also experiencing left shoulder pain that is rated as 6-7/10. His pain is rated as 9/10 during his most recent progress report, rated as 4/10 with use of pain medication. Physical examination identifies limited range of motion with lumbar muscle spasm, a positive FABERE on the left with tenderness over the greater trochanter. Neurologically, has reflex deficit at the left Achilles (absent), whereas all other tested reflexes are +1. Left shoulder range of motion is limited with apparent positive impingement signs. Imaging studies include a lumbar MRI that identifies lumbar degenerative joint disease, severe facet arthrosis at L5-S1 with face overgrowth and neuroforaminal compromise. Previous treatment has consisted of medications and exercise. The medications help keep him functional. In dispute is a decision for Xartemis 8.5mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Xartemis 7.5mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Intervention and Treatments Page(s): 75,88,91.

**Decision rationale:** Short-acting opioids: also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. Dosage should be based on the oxycodone content and should be administered every 4 to 6 hours as needed for pain. Initially 2.5 to 5 mg PO every 4 to 6 hours as needed (prn) may all this required to provide analgesia. Note: Maximum daily dose is based on acetaminophen content (Maximum 4000mg/day). For more severe pain the dose (based on oxycodone) is 10-30mg every 4 to 6 hours prn pain. The continued use of such medication needs periodic reassessment. This should Document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Unfortunately, not enough descriptive documentation is done in describing the patient's response to the medications as compared to baseline. This is essential in ensuring appropriate care delivery when utilizing opioid pain medication. I find that the request does not meet criteria for continuation of treatment and is not medically necessary.