

<b>Case Number:</b>	CM14-0218083		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	04/09/1996
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	12/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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. 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: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 55-year-old female with a date of injury on 04/09/1996. Medical records provided did not indicate the injured worker's mechanism of injury. Documentation from 04/18/2014 indicated the diagnoses of post lumbar laminectomy syndrome, lower complex regional pain syndrome, anxiety disorder not otherwise specified, neck pain/cervalgia, lymphoplasmacytic sclerosing cholangitis, low back pain, sacroiliitis, spinal cord stimulation implant with spinal cord stimulation explant, status post lumbar fusion, and status post lumbar fusion revision performed in 2007. Subjective findings noted on 11/26/2014 were remarkable for bone pain from the hips down, nausea, anxiety, increase in crying episodes, and insomnia. Physical examination from the same date was remarkable for severe lumbar spine tenderness, wide gait, significant reduction in range of motion in all directions with pain, lower extremity weakness, fatigue, acute distress, and periods of crying. Progress note from 04/18/2014 noted computed tomography from 03/2007 that was revealing for degenerative disc disease with grade I anterolisthesis at lumbar four to five and bilateral foraminal narrowing; electrodiagnostic study performed on 06/2008 that was revealing for chronic denervation/reinervation changes in the lower lumbar segments noted to be chronic; and lumbar magnetic resonance imaging performed on 08/2010 that was remarkable for surgical scarring and granulation tissue at laminectomy sites, abutting the posterior aspect of the thecal sac, and hypertrophic changes at lumbar three through sacral one facets. Prior treatments offered to the injured worker included aquatic therapy, Dilaudid and Phenergan injections, right and left sacroiliac joint injections, and a medication history of Provigil, Ativan, Soma, Cymbalta,

Lidocaine-prilocaine topical, Oxycodone IR, Opana ER, Prednisone, Alendronate, Colace Sodium, Senna, Opana, Rozerem, Xanax, and intravenous Rituxan. Medical records included two aquatic therapy notes and noted the injured worker to have difficulty with progressing exercises secondary to pain. However, the medical records lacked the total quantity of visits provided, treatment plan, and documentation of functional improvement, improvement in work function, or in activities of daily living. Progress note from 11/26/2014 noted that the injured worker's medication regimen helped relieve symptoms and improve function including accomplishing activities of daily living, but when she misses a dose of her medications she was noted to have increased difficulty with activities of meal preparation and light housework. Medical records provided lacked documentation of a work or disability status. On 12/12/2014, Utilization Review modified the prescription for Oxycodone 30mg with a quantity of 180 to Oxycodone 30mg with a quantity of 101 between 11/26/2014 and 02/07/2015. The prescription for Oxycodone was modified based on California Chronic Pain Treatment Guidelines with the Utilization Review noting that the injured worker is taking approximately four times the recommended dose with documentation noting an increase in pain, along with lacked of documentation indicating significant functional improvement. The Utilization Review further noted Oxycodone to be modified for weaning purposes.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **(1) Prescription of Oxycodone 30 mg #180: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OxyContin, Opioids on-going management.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78,88-89.

**Decision rationale:** The patient presents with complains of neck pain, abdominal pain, low back and right lower extremity pain. The request is for prescription of Oxycodone 30 mg # 180. The pain is rated at 9/10. Patient is status post lumbar fusion revision and SCS implant with SCS explant, dates not specified. Patient's work status is not provided. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Patient has been prescribed Oxycodone from 04/18/14 and 11/26/14. In this case, treater has not discussed how Oxycodone significantly improves patient's activities of daily living. The treater does not document measurable increase in activities of daily living due to prolonged opioid use. Urine analysis test dated 01/25/14 showed results consistent with patient's medications, however no discussions regarding aberrant behavior were provided. Per progress report dated 11/26/14, treater states that UDS and CURES reports were reviewed, however, no results were available for review of medical records. MTUS requires appropriate discussion of

the 4A's. Given the lack of documentation as required by guidelines, the request is not medically necessary.