

<b>Case Number:</b>	CM15-0012616		
<b>Date Assigned:</b>	01/30/2015	<b>Date of Injury:</b>	06/30/2008
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 47-year-old female, with a reported date of injury of 06/30/2008. The diagnoses include lumbar sprain, Cervicalgia, shoulder, knee and leg sprain. There is an associated diagnosis of depression. Investigations included an MRI , which showed stenosis and electrodiagnostic study of bilateral lower extremity on 09/10/2014, which showed chronic bilateral L5 radiculopathy. The treatments completed are PT and medications. The progress report dated 12/23/2014 indicates that the injured worker was still having back and leg pain. The objective findings included range of motion with complaint of pain and positive left straight leg raise test. The treating physician requested Oxycodone/acetaminophen. The medications listed are oxycodone, compound analgesic cream and gabapentin. The UDS dated 11/20/2014 was noted to be consistent with prescribed oxycodone. Some parts of the hand written progress notes are not legible. On 12/31/2014, Utilization Review (UR) modified the request for Oxycodone/acetaminophen 10/325mg #90, noting that there was no documentation of functional improvement with the use of this medication, or the improvement of psychosocial functioning. The MTUS Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone/APAP 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 74-96, 124. Decision based on Non-MTUS Citation Pain Chapter Opioids

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that opioids can be utilized for the treatment of severe musculoskeletal pain that did not respond to standard treatment with NSAIDs and PT. The records did not show that the patient failed treatment with standard NSAIDs, co-analgesics and PT. The chronic use of opioids is associated with the development of tolerance, dependency, addiction, sedation and adverse interaction with other sedative medications. The complications are significantly increased in patients with a co-existing history of psychiatric disorders. The guidelines recommend that antidepressants with analgesic action be utilized in chronic pain patients who are diagnosed with co-existing depression disorder. The records did not indicate that the patient is being effectively treated for the diagnosed depression. There is no documentation of the guidelines required compliance monitoring of absence of aberrant drug behaviors and functional restoration. The criteria for the use of Oxycodone 10/325mg #90 was not met.