

<b>Case Number:</b>	CM15-0110965		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	06/04/2003
<b>Decision Date:</b>	07/22/2015	<b>UR Denial Date:</b>	06/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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: California, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

### 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 55-year-old female who sustained an industrial injury on 06/04/13. Initial complaints and diagnoses are not available. Treatments to date include medications, spinal cord stimulator, and back surgery. Diagnostic studies are not addressed. Current complaints include chronic low back pain with lower extremity radicular symptoms. Current diagnoses include low back pain, backache, primary fibromyalgia, thoracic or lumbosacral neuritis/radiculitis, lumbar spinal stenosis, post laminectomy syndrome, displacement of lumbar intervertebral disc, and backache. In a progress note dated 04/08/15 the treating provider reports the plan of care as medications including alprazolam, cyclobenzaprine, and hydrocodone/acetaminophen, as well as cognitive behavioral therapy. The requested treatments include hydrocodone/acetaminophen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone/Acetaminophen 10/325mg #45:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for oxycodone/acetaminophen, California Pain Medical Treatment Guidelines state that oxycodone is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that this medication is improving the patient's function (in terms of specific examples of objective functional improvement), and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested oxycodone/acetaminophen is not medically necessary.