

<b>Case Number:</b>	CM15-0074174		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	05/06/2002
<b>Decision Date:</b>	05/27/2015	<b>UR Denial Date:</b>	03/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/18/2015

### 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: New York, Tennessee

Certification(s)/Specialty: Emergency 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 72 year old female, who sustained an industrial injury on 05/06/2002. She has reported subsequent back pain and was diagnosed with L3-S1 spondylolisthesis, degenerative disc disease and scoliosis. Treatment to date has included oral pain medication, steroid injections, spinal cord stimulator, chiropractic treatment and surgery. In a progress note dated 03/03/2015, the injured worker complained of severe back pain and muscle spasms and inability to stand up straight or bear weight on the left leg. Objective findings were notable for an antalgic gait, inability to stand up straight, muscle spasm in the lumbar trunk, pain with straight leg raise on the right and left at 80 degrees, sensory loss to light touch and pinprick at the left lateral calf and bottom of the foot and absent left Achilles reflex. A request for authorization of an Oxycontin refill was made.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 80mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines When to Continue Opioids, Opioids for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

**Decision rationale:** Oxycontin is an extended release preparation of oxycodone. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case the patient has been receiving since oxycodone at least July 2013 and has not obtained analgesia. In addition the daily opioid dosage for oxycodone is 360 mg morphine equivalents. This exceeds the daily recommended maximum of 120 mg morphine equivalents. Criteria for long-term opioid use have not been met. The request is not medically necessary.