

<b>Case Number:</b>	CM15-0090732		
<b>Date Assigned:</b>	05/15/2015	<b>Date of Injury:</b>	02/10/2006
<b>Decision Date:</b>	06/25/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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, Hawaii

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:

The injured worker is a 55 year old, female who sustained a work related injury on 2/10/06. The diagnoses have included right sacroiliitis, chronic back pain status post lumbar surgery x 2, lumbar radiculopathy and lumbar myofascial strain. Treatments have included oral medications, Lidoderm patches, use of a cane, a right sacroiliac joint injection, physical therapy, massage therapy, heat/ice therapy, TENS unit therapy, acupuncture, chiropractic treatments and epidural injections. In the PR-2 dated 3/31/15, the injured worker complains of increased, constant, aching low back pain. She has radiation of pain, numbness and weakness into both legs, left worse than right. She rates her pain level an 8-9/10. She states activity increases back pain. She has tenderness to lumbar area and right sacroiliac area. She has limited range of motion in lumbar area. The treatment plan includes a recommendation to continue with OxyContin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Month Supply of Oxycontin 30 MG Tab:** Overturned

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

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

**Decision rationale:** The patient presents with chronic low back pain with radiation, numbness and weakness into the bilateral extremities, left worse than right. The current request is for 1-month supply of OxyContin 30 mg tab. The treating physician requests on 3/31/15 (24B) to "continue with OxyContin 30mg #90 to transition patient from high frequency short acting narcotics to sustained release for chronic pain." For chronic opiate use, 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 aberrant 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. In this case, the treating physician documents the patient's analgesia at 15% decreased with medication usage and improved tolerance for ADLs. Additionally there is documentation of lack of adverse side effects and aberrant behaviors while on her current medication regimen. The patient's UDS results on 9/17/14 were consistent with her medication profile and CURES was consistent. The current request is medically necessary and the recommendation is for authorization.