

<b>Case Number:</b>	CM14-0146048		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	07/10/2001
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	08/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 54 year old male injured on 07/10/01 while performing normal and customary duties as a truck driver resulting in unspecified injury. Current diagnoses include degenerative spondylosis of the lumbar spine, lumbago, and muscle spasms. The clinical note dated 06/10/14 indicated the injured worker presented complaining of pain rated at 8/10 on visual analog scales (VAS) worsened due to difficulty with medication authorization. The injured worker reported poor sleep due to stress and pain averaging approximately four hours per night. The injured worker continued exercising, walking, and stretching; however, reported cramps in the legs and spasms in the low back. Objective findings included ambulating with an antalgic gait, severe pain in the lower back, no spasms noted, T12 to S4 intact. Treatment plan included continuation with current medication regimen including Oxycontin, Oxycodone, and Amrix. The initial request was noncertified on 08/19/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 15mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As such, Oxycodone 15 milligrams quantity sixty is not medically necessary.