

Case Number:	CM13-0004798		
Date Assigned:	06/11/2014	Date of Injury:	08/08/1997
Decision Date:	07/31/2014	UR Denial Date:	07/15/2013
Priority:	Standard	Application Received:	07/28/2013

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 Occupational Medicine, and is licensed to practice in California. 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 claimant was injured on August 8, 1997. Percocet is under review. [REDACTED] completed a medical-legal supplemental report on February 22, 2011. The claimant had low back injury and ongoing low back and neck pain. He was thought he was a poor candidate for an intrathecal pump for spinal cord stimulator. Lumbar radiofrequency ablation, sacroiliac joint injections, and ESI's (epidural steroid injections) were under consideration. He saw [REDACTED] on December 19, 2012. He was doing better with methadone and Percocet for breakthrough pain. He was taking methadone three times per day and Percocet up to three times per day between the methadone doses. His pain was much better controlled with this regimen. He denied any significant side effects or problems. The low back pain had continued to improve somewhat as a result of the most recent injections. He also started low dose gabapentin and baclofen. On January 22, 2013 he stated he wanted to decrease the methadone and increased the Percocet. He was on Canadian crutches and had an antalgic gait with difficulty with balance and support of his weight. He had findings of tenderness and a positive straight leg raise test on the right side. Diagnoses included neck pain with left upper extremity radiculopathy, low back pain with left lower extremities radiculopathy, postlaminectomy syndrome, myofascial syndrome, SI joint arthropathy bilaterally, painful hardware, bilateral hand and wrist pain, likely carpal tunnel syndrome versus tendinitis secondary to chronic crutch use. He had GI (gastrointestinal) symptoms due to the medications and greater trochanteric bursitis. The methadone was decreased and the Percocet was increased. He underwent epidural steroid injections of the lumbar spine on July 24, 2013. He reported improvement with his pain control on April 19, 2013 with the change in medication. On May 22, 2013, he reported having significant pain in his neck and his left leg. He was significantly impaired functionally because of pain. He did not feel his medications were managing the pain. On June 21, 2013, he reported ongoing significant

pain. He stated Percocet was more helpful than methadone. Methadone was decreased and the Percocet was increased. On May 13, 2014, he reported that his low back pain was somewhat improved but his neck was bothering him more. Returning to methadone helped somewhat. He wanted to be able to take Percocet up to threetimes per day as needed and the methadone two per day. The medications were changed again. ESI's were under consideration. He had gotten benefit from previous injections. An MRI of the cervical spine dated January 30, 2014 showed multilevel changes with intervertebral disc disease and degenerative changes. On February 11, 2014, he still had significant pain. He had been at seen in the ER and almost was admitted but he declined. The switch to Percocet was not managing his pain and he wanted to switch back to methadone. Methadone was started again. Percocet was decreased to 1 every 12 hours. He was admitted to a hospital on January 31, 2014 for chronic neck and back pain. He stated he normally takes OxyContin for pain relief. His pain had increased to 10/10 recently. He recently had MRI of the neck and back. He only mentioned taking OxyContin. He was discharged on February 3, 2014. He was to continue his OxyContin. He had a lumbar spine MRI while in the hospital, also. On January 17, 2014, he saw [REDACTED] and was struggling with significant pain. He requested a switch to a higher frequency of Percocet which was more effective and better tolerated than methadone. He had improvement with the left L4 and L5 transforaminal ESI's on July 24, 2013 but the improvement had waned. He was to wean the methadone off and then increase to Percocet to one every five hours as needed for pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg, 150 count: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and the 4 A's Page(s): 110.

Decision rationale: The history and documentation do not objectively support the request for ongoing use of the opioid, Percocet and weaning should be done. The Chronic Pain Medical Treatment Guidelines outlines several components of initiating and continuing opioid treatment and states a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. The Chronic Pain Medical Treatment Guidelines further explains, pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. There is also no indication that periodic monitoring of the claimant's pattern of use and a response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that he has been involved in an ongoing rehab program to help maintain any benefits he received from treatment measures. Additionally, the 4A's analgesia, activities of daily living, adverse side

effects, and aberrant drug-taking behaviors should be followed and documented per the guidelines. The claimant's pattern of use of Norco is unclear other than he appears to take it regularly. There is no evidence that a signed pain agreement is on file at the provider's office and no evidence that a pain diary has been recommended. The request for Percocet 10/325 mg, 150 count, is not medically necessary or appropriate.