

<b>Case Number:</b>	CM14-0003105		
<b>Date Assigned:</b>	01/31/2014	<b>Date of Injury:</b>	12/10/1993
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	12/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2014

### 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 Physical Medicine and Rehabilitation, 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 patient is a 51 year old male injured on 12/10/93 due to undisclosed mechanism of injury. The patient received routine evaluations and pain management for chronic lumbar pain, recurrent myofascial strain, and radicular pain in the lower extremities. The patient was status post lumbar spine fusion at three levels and diagnosed with failed lumbar back surgery syndrome with intermittent exacerbations of neuropathic pain and myofascial strain. Medication management included Ibuprofen, Senokot, Norco 325-10mg Q46 hours with a max of five per day, and AndroGel 1%. The patient also required intrathecal pain pump placement with Morphine 0.7mg per/day and Bupivacaine 3.5mg/day. The patient reported constant low back pain radiating to the left leg rated at 7/10 with 30% reduction in pain from intrathecal pain medications. The patient reported good pain control from current opioid pain medications, increased physical activity, increase in activities of daily living, and increase in mood and sleep. There were inconsistent drug screens noted in the clinical documentation. Norco 10/325 mg (#200) and Percocet 10/325 mg (#30) have been requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NORCO 10/325 MG 1 EVERY FOUR TO SIX (4-6) HOURS, MAXIMUM OF FIVE (5) PER DAY (#200):** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for the Use of Opioids. .

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use.

**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 sufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. In addition, opioid risk assessments regarding possible dependence or diversion were also discussed. As the clinical documentation provided for review supports an appropriate evaluation for the continued use of narcotics as well as establishes the efficacy of narcotics, Norco 10/325 Mg 1 Every Four To Six (4-6) Hours, maximum of five (5) per day (#200) is recommended as medically necessary at this time.

**PERCOCET 10/325 MG, EVERY FOUR TO SIX (4-6) HOURS FOR BREAK THROUGH PAIN, MAXIMUM OF 1 PER DAY (#30):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for the Use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Opioids, Criteria For Use.

**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 sufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. In addition, opioid risk assessments regarding possible dependence or diversion were also discussed. As the clinical documentation provided for review supports an appropriate evaluation for the continued use of narcotics as well as establishes the efficacy of narcotics, Percocet 10/325 mg, every four to six (4-6) hours for break through pain, maximum of 1 per day #30 is recommended as medically necessary at this time.