

<b>Case Number:</b>	CM14-0130265		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	07/25/1997
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2014

### 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 Pain Medicine, and is licensed to practice in Texas and Oklahoma. 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 63-year-old female who reported an injury on 07/25/1997. The mechanism of injury was not provided. On 08/14/2014, the injured worker presented for a followup. The diagnoses were chronic pain state involving the bilateral upper and lower extremities, neck, and upper/lower back regions, hypertension, hypothyroidism. The current medications included Xopenex, Butrans, tramadol, Percocet, Alendronate. The provider recommended Percocet 10/325 mg #60. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Workers Compensation Drug Formulary; Physicians Desk Reference.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

**Decision rationale:** The request for Percocet 10/325mg #60 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic

pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse behavior, and side effects. As such, the request is not medically necessary.