

<b>Case Number:</b>	CM14-0039670		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	11/09/1997
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	03/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/04/2014

### 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 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 injured worker is a male with date of injury 11/9/1997. Per workers' compensation note dated 3/11/2014, the injured worker follows up for chronic back pain, osteoarthritis/degenerative joint disease, chronic constipation due to the medication, chronic muscle spasms and bilateral shoulder pain. His right hand weakness has improved. His pain is controlled with the present plan of treatment. He is functional at home. Examination of the lumbar spine revealed bilateral sacroiliac joint tenderness. No points of tenderness in the lumbosacral area. No muscle spasms. Upper extremity motor power is normal. Lower extremity motor power is normal. The shoulders reveal minimal tenderness. He has full range of motion, no muscle wasting and grip on both hands is equal and normal. Diagnoses include: chronic back pain, osteoarthritis/degenerative joint disease, chronic muscle spasms, chronic constipation, status post left shoulder surgical treatment times two, status post right shoulder surgery, right hand motor power weakness, resolved.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg # 120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications section Page(s): 74-95, 124.

**Decision rationale:** The injured worker is taking Oxycontin 80 mg twice a day and Percocet 10/325 mg one tablet every 6 hours. This equates to a morphine equivalent dose of 300 mg per day. The claims administrator approved the continued use of Oxycontin as it is recommended for the management of moderate to severe pain when a continuous analgesic is needed. The Oxycontin dosing alone equates to a morphine equivalent dose of 240 mg per day. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. They do provide guidance on the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy, which is not the case in the current management of this injured worker. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. This injured worker is already taking a high dose of Oxycontin at morphine equivalent dose of 240 mg per day, in excess to the 120 morphine equivalent per day ceiling recommended by the MTUS Guidelines. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Percocet 10/325 mg #120 is determined to not be medically necessary.

**Provigil 200 mg # 30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic Pain.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG, Pain chapter, Modafinil (Provigil) section.

**Decision rationale:** The MTUS Guidelines do not address the use of Provigil. The ODG does not recommend the use of Provigil solely to counteract sedation effects of narcotics until after first considering reducing excessive narcotic prescribing. Provigil is indicated to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea, and shift work sleep disorder. Patients should have a complete evaluation with a diagnosis made in accordance with the International Classification of Sleep Disorders or DSM diagnostic classification. The medical reports provided for review do not establish medical necessity for the use of Provigil within these guidelines. The request for Provigil 200 mg #30 is determined to not be medically necessary.