

<b>Case Number:</b>	CM14-0059244		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	08/09/2005
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	04/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2014

### 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 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 51-year-old female who reported an injury on 08/09/2005. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar spondylolisthesis; status post fusion at L4-5 and L5/S1; reflex symptomatic sympathetic dystrophy, left leg; postoperative regional pain syndrome. The previous treatments included medication and surgery. Within the clinical note dated 03/14/2014 it was reported the injured worker complained of mid back and low back pain. She described her pain as frequent, mild to moderate pain with stiffness. She complained of lower extremity pain which she described as constant, numbness and tingling pain. Upon the physical examination the provider noted the injured worker to have 1 to 2+ tenderness and muscle guarding bilaterally along the paravertebral and lower trapezius muscles. Upon examination of the lumbar spine, the provider noted 2+ tenderness along T8 through T12 and L1 through L5. The range of motion was flexion at 35 degrees, and extension at 15 degrees. The request submitted is for Percocet; however, a rationale was not provided for clinical review. The request for authorization was not provided for clinical review.

### 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, to allow the patient this one refill of percocet for the purpose of weaning to discontinue, with a reduction of med by 10%-20% per week over weaning period of 2-3 months requested x 2 units: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Opioid. Decision based on Non-MTUS Citation ODG-pain chapter, opioids, long acting.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

**Decision rationale:** The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen in patient treatment with issues of abuse, addiction, or pain control. There is lack of documentation indicating the efficacy of the medication as evidence by significant functional improvement. The provider failed to document an adequate and complete pain assessment. The request submitted failed to provide the frequency of the medication. The injured worker has been utilizing the medication since at least 09/2013; therefore, the request for Percocet 10/325mg #120 with 1 refill is not medically necessary.