

<b>Case Number:</b>	CM14-0078378		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	05/25/2012
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	05/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2014

### 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, has a subspecialty in Pain Medicine, and is licensed to practice in California and Virginia. 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 39-year-old male who sustained an industrial injury on 5/25/2012, when he jumped off a 5-foot fence, landed on both feet and experienced immediate right hip pain. Lumbar disc herniation is the accepted injury. On 4/16/2014, the patient returned to follow up with report of continued intermittent low back pain with occasional right foot pain. He often times has difficulty sleeping due to pain and states medication given in the office appears to help with symptoms. Objectively, there is no tenderness to palpation, no deformity, and no spasm of the lumbar spine or lumbar paraspinal musculature. Active voluntary thoracolumbar range of motion (ROM) is limited, he is able to forward flex 45 and extend 10 before experiencing low back pain, and lateral bending is limited to 15 bilaterally. There is difficulty performing right side heel walk and evidence of antalgic gait on the right when performing the maneuver. The straight leg raise (SLR) test is mildly positive on the right, motor examination is normal, sensory exam is intact, and reflexes are symmetric bilaterally. He was provided refills of medications and remains permanent and stationary. He was to follow up in 3 months or sooner if needed. He was dispensed Naprosyn EC 500mg #60 with 3 refills and Elavil 25 mg #30 with 3 refills and was prescribed Percocet 5/325mg #50. According to the 7/17/2014 progress report, the patient is still working. Overall, he is doing fairly well. He only requires strong analgesics on rare occasions. On examination, voluntary thoracolumbar ROM is limited; he is able to flex 45 and extend 10 before experiencing low back pain, and lateral bending is limited to 15 bilaterally. Seated and supine SLR test is negative at 70, and femoral stretch is also negative. Motor examination is normal in lower extremities, sensation is normal, and reflexes are symmetrical. Hip ROM is full bilaterally, with no groin or hip pain on ROM. Independent core strengthening was discussed with the patient. He remains permanent and stationary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 5/325mg QTY:1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone/Acetaminophen Page(s): 92 of 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** According to the California MTUS guidelines, Percocet is a short-acting opioid which is recommended for short-term pain relief; the long-term efficacy is unclear (greater than 16 weeks), but also appears limited. According to guidelines, the use of opioids for chronic back pain appears to be efficacious but limited for the treatment of significant, moderate to moderately severe pain that has not been adequately responsive to non-opioid analgesics. Failure to respond to a time-limited course of opioids has led to the suggestion of re-assessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicates that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. According to the 4/16/2014 progress report, this patient has intermittent pain. The pain level is not quantified. He has minimal findings of limited lumbar ROM due to pain and mildly positive SLR on the right; otherwise, there are no limitations or functional deficits. The examination on 7/10/14 does not document any pain complaint and objective findings are normal except for pain with active lumbar ROM. The medical records fail to establish that the patient has significant, moderate to moderately severe pain that has not been adequately responsive to non-opioid analgesics. Chronic use of opioids for non-malignant pain is not generally recommended. The medical necessity of Percocet in this case has not been established.