

<b>Case Number:</b>	CM14-0167856		
<b>Date Assigned:</b>	10/31/2014	<b>Date of Injury:</b>	08/10/1988
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 68 year old female with an industrial injury dated 08/10/1988. The injured worker's diagnoses include chronic pain syndrome, osteoarthritis localized primary lower leg, disc degeneration of lumbar/lumbosacral and lumbar region disc disorder. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In a progress note dated 07/14/2014, the treating physician reported that the injured worker had been using medications as expected and was demonstrating fair analgesia with no negative side effects. The treating physician also reported that the urine drug test had been consistent with program and the injured worker had no aberrant prescribing behavior. Objective findings revealed generalized tenderness in the lumbar area, sacral, coccygeal and pelvic area. Treatment plan consisted of medication management. The treating physician prescribed Kadian 100 mg 1 cap by mouth four times a day #240 and Percocet 10/325 mg, 1 tablet by mouth, four times a day, #120 now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kadian 100mg 1 cap by mouth four times a day #240: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

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

**Decision rationale:** MTUS Guidelines cite opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury without acute flare, new injury, or progressive deterioration. The Kadian 100 mg 1 cap by mouth four times a day #240 is not medically necessary and appropriate.

**Percocet 10/325 mg, 1 tablet by mouth, four times a day, # 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

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

**Decision rationale:** Pain symptoms and clinical findings remain unchanged for this chronic injury. Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or returned to work status. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury. In addition, submitted reports have not adequately demonstrated the specific indication to support for chronic opioid use without acute flare-up, new injuries, or progressive clinical deficits to support for chronic opioids outside recommendations of the guidelines. The Percocet 10/325mg, 1 tablet by mouth, four times a day, #120 is not medically necessary and appropriate.