

<b>Case Number:</b>	CM14-0198406		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	09/17/2002
<b>Decision Date:</b>	01/23/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Rehab, has a subspecialty in Interventional Spine 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 56 year old male with an injury date on 09/17/2002. Based on the 11/09/2014 progress report provided by the treating physician, the diagnoses are: 1. Spondylolisthesis 2. Lumbago 3. Low back pain; low back syndrome; lumbalgia. According to this report, the injured worker complains of low back pain that is a 5-6/10 on the pain scale. Physical exam reveals tenderness at the lumbar paraspinal muscles. Range of motion is decreased. Straight leg raising test is positive at 70 degrees in sitting position. The 09/21/2014 report indicates injured worker is "not sleeping well, 6/10 pain, needs refill Percocet and tramadol." This month, the injured worker notice an "increased pain, decreased function without tramadol, even Percocet." The treatment plan is to request for compound cream and refill medications. The injured worker's work status is "medically retired." There were no other significant findings noted on this report. The utilization review denied the request for Percocet 10/325mg and Diclofenac 3%, Baclofen 2%, Bupivacaine 1%, MDSO 4 %, Gabapentin 6 %, Ibuprofen 3 % and Pentoxifylline 3%, 120 gram 11/19/2014 based on the MTUS guidelines. The requesting physician provided treatment reports from 02/17/2013 to 09/21/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 60-61; 88-89; 76-78.

**Decision rationale:** The current request is for Percocet 10/325mg. This medication was first mentioned in the 02/17/2013 report; it is unknown exactly when the injured worker initially started taking this medication. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Review of the provided reports show documentation of pain assessment but no before and after analgesia is provided. The treating physician does not discuss specific improvement in ADLs or document functional improvement. A recent UDS was obtained but result was not discussed. Outcome measures are not documented as required by MTUS. No valid instruments are used to measure the injured worker's function which is recommended once at least every 6 months per MTUS. The treating physician has failed to clearly document ADL's, Adverse effects and Adverse behavior as required by MTUS. The request is not medically necessary.

**Diclofenac 3%, Baclofen 2%, Bupivacaine 1%, MDSO 4%, Gabapentin 6%, Ibuprofen 3% and Pentoxifylline 3% 120 Grams:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Cream Page(s): 111-113.

**Decision rationale:** The current request is for Diclofenac 3%, Baclofen 2%, Bupivacaine 1%, MDSO 4%, Gabapentin 6%, Ibuprofen 3% and Pentoxifylline 3% 120 Grams. Regarding topical compounds, MTUS states that if one of the compounded products is "not recommended then the entire compound is not recommended." MTUS further states "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS also does not support Gabapentin as a topical product. The current request is not medically necessary.