

<b>Case Number:</b>	CM15-0132306		
<b>Date Assigned:</b>	07/20/2015	<b>Date of Injury:</b>	03/16/2000
<b>Decision Date:</b>	08/19/2015	<b>UR Denial Date:</b>	07/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2015

### 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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 50 year old male, who sustained an industrial injury on 3/16/2000. Diagnoses include post lumbar laminectomy syndrome and low back pain. Treatment to date has included multiple surgical interventions of the lumbar spine (2000, 2007, 2008 and 2014), and surgical intervention of the right shoulder (undated), as well as conservative measures including diagnostics, medications, physical therapy, lumbar epidural steroid injections, acupuncture, chiropractic, biofeedback, psychotherapy, home exercise, facet joint injections, trigger point injections and steroid injection to the elbow. Per the Primary Treating Physician's Progress Report dated 7/02/2015, the injured worker reported lower backache. He states that pain has increased since his last visit. He rates his pain as 2/10 with medications and 9/10 without medications. Physical examination revealed loss of normal lordosis with straightening of the lumbar spine and surgical scars. Range of motion was restricted upon flexion and extension. On palpation, paravertebral muscles spasm and tenderness was noted on both sides. The plan of care included opioid pain medication and authorization was requested for Percocet 10/325mg #120. The medication list include MS contin, Percocet and Ativan The patient has had UDS on 5/7/15 that was consistent for Oxycodone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #120 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines -Opioids, criteria for use: page 76-80 CRITERIA FOR USE OF OPIOIDS Therapeutic Trial of Opioids.

**Decision rationale:** Request Percocet 10/325mg #120 with 1 refill. Percocet contains acetaminophen and oxycodone which is an opioid analgesic. According to CA MTUS guidelines cited below, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." The records provided do not specify that patient has set goals regarding the use of opioid analgesic. A treatment failure with non-opioid analgesics is not specified in the records provided. Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of the overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." The records provided do not provide a documentation of response in regards to pain control and functional improvement to opioid analgesic for this patient. The continued review of overall situation with regard to nonopioid means of pain control is not documented in the records provided. As recommended by MTUS a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these are not specified in the records provided. The level of pain control with other non opioid medications ( antidepressants/ anticonvulsants), was not specified in the records provided. Whether improvement in pain translated into objective functional improvement including ability to work is not specified in the records provided. With this, it is deemed that, this patient does not meet criteria for ongoing continued use of opioids analgesic. The Percocet 10/325mg #120 with 1 refill is not medically necessary for this patient, given the records submitted and the guidelines referenced. If this medication is discontinued, the medication should be tapered, according to the discretion of the treating provider, to prevent withdrawal symptoms.