

<b>Case Number:</b>	CM15-0163289		
<b>Date Assigned:</b>	08/31/2015	<b>Date of Injury:</b>	10/12/2009
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	08/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 30 year old male, who sustained an industrial injury on 10-12-2009. The mechanism of injury is unknown. The injured worker was diagnosed as having lumbar degenerative disc disease, lumbar 5-sacral 1 disc replacement, chronic pain syndrome, myalgia and myositis and sacroiliitis. There is no record of a recent diagnostic study. Treatment to date has included lumbar fusion, physical therapy and medication management. In a progress note dated 8-3-2015, the injured worker complains of low back pain radiating down the back of both hamstrings rated 7 out of 10 without medications and 4 out of 10 with medications. Physical examination showed pain and spasm across the lumbosacral area. The treating physician is requesting Percocet 10-325 mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg po bid tid #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for Percocet (Oxycodone/acetaminophen), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no statement of Percocet being part of a treatment plan, no indication that an opiate agreement is in place, and no statement indicating what objective treatment goals are intended to be addressed with the use of this medication. In the absence of such documentation, the currently requested Percocet (Oxycodone/acetaminophen) is not medically necessary.