

<b>Case Number:</b>	CM15-0199185		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	04/19/2004
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2015

### 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: Florida  
 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 61 year old male, who sustained an industrial-work injury on 4-19-04. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar radiculitis. Medical records dated (4-17-15 to 7-17-15) indicate that the injured worker complains of chronic low back pain which the injured worker indicates has been fairly stable, with some cramping at times in the right lower back that extends to the thigh which he controls with maneuvers. Per the treating physician report dated 7-17-15, the injured worker has returned to work. The physical exam dated from (4-17-15 to 7-17-15) reveals that there is tenderness in the lumbosacral area, more on the right side than the left side. There is limitations with extension more than flexion, otherwise the gait and neurovascular exam remain stable. There are no documented VAS pain scores. Treatment to date has included pain medication such as Motrin, Norco and Percocet since at least 4-17-15. The treating physician indicates that the urine drug test result was consistent with the medication prescribed. The requested service included Percocet 10-325mg 1-2 Q4-6 hours #240, 2 refills. The original Utilization review dated 9-16-15 modified the request for Percocet 10-325mg 1-2 Q4-6 hours #240, 2 refills modified to Percocet 10-325mg 1-2 Q4-6 hours #240, with 0 refills for weaning.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg 1-2 Q4-6 hours #240, 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**Decision rationale:** In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if "(a) If the patient has returned to work, (b) If the patient has improved functioning and pain." MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is no objective evidence of continued functional improvement. Likewise, this requested chronic narcotic pain medication is not considered medically necessary.