

<b>Case Number:</b>	CM15-0020627		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	07/14/2006
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2015

### 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: Georgia

Certification(s)/Specialty: Anesthesiology, 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 55 year old female, who sustained an industrial injury on 07/14/2006. She has reported low back pain. The diagnoses have included lumbosacral sprain/strain; and lumbar degenerative disc disease. Treatments have included medications and acupuncture sessions. Medications have included Norco, Zanaflex, and Ibuprofen. Currently, the injured worker complains of ongoing back pain with shooting pain in her right leg more than the left; pain is rated at 9/10 on the visual analog scale, and 4/10 at best with the medications; and back spasms. A progress note from the treating physician, dated 12/31/2014, reported objective findings to include ambulation with a limp; and limited range of motion of the back. The treatment plan included prescription for Percocet, Zanaflex, and Ibuprofen. On 01/16/2015 Utilization Review noncertified 1 prescription of Percocet 10/325 mg #120. The CA MTUS was cited. On 01/22/2015, the injured worker submitted an application for review of Percocet 10/325 mg #120.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 79.

**Decision rationale:** Percocet 10/325mg # 120 is not medically necessary. Per MTUS page 79 of MTUS guidelines states that weaning of opioids are recommended if; (a) there are no overall improvement in function, unless there are extenuating circumstances. (b) continuing pain with evidence of intolerable adverse effects. (c) decrease in functioning. (d) resolution of pain. (e) if serious non-adherence is occurring. (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore, the requested medication is not medically necessary.