

<b>Case Number:</b>	CM15-0217793		
<b>Date Assigned:</b>	11/09/2015	<b>Date of Injury:</b>	12/04/1978
<b>Decision Date:</b>	12/23/2015	<b>UR Denial Date:</b>	10/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2015

### 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: Pennsylvania, Ohio, California  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 71 year old male, who sustained an industrial injury on 12-4-1978. Medical records indicate the worker is undergoing treatment for lumbar spondylolisthesis, lumbar stenosis and lumbar radiculopathy. A progress note from 3-30-2015 reported the injured worker complained of low back pain rated 9 out of 10. The most recent progress report dated 8-4-2015, reported the injured worker complained of severe low back pain rated 10 out of 10, with radiation occupational therapy the bilateral lower extremities-right worse than left. Physical examination revealed "decreased lumbar range of motion", bilateral antalgic gait and bilateral positive sciatic notch tenderness. Radiology studies showed multilevel lumbar degenerative disc disease abdominal foraminal narrowing. Treatment to date has included physical therapy and Percocet (since at least 3-2015). The physician is requesting Percocet 10-325mg #180. On 10-24-2015, the Utilization Review modified the request for Percocet 10-325mg #180.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Weaning of Medications.

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

**Decision rationale:** MTUS discusses in detail the 4 As of opioid management, emphasizing the importance of dose titration vs. functional improvement and documentation of objective, verifiable functional benefit to support an indication for ongoing opioid use. The records in this case do not meet these 4As of opioid management and do not provide a rationale or diagnosis overall for which ongoing opioid use is supported. Therefore this request is not medically necessary.