

<b>Case Number:</b>	CM15-0041161		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	04/06/2005
<b>Decision Date:</b>	04/15/2015	<b>UR Denial Date:</b>	02/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2015

### 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: 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 46-year-old male, who sustained an industrial injury on April 6, 2005. The injured worker had reported a low back pain. The diagnoses have included lumbar disc protrusions, chronic low back pain, radiculitis of the bilateral lower extremities, thoracic sprain, cervical strain, cervical disc protrusions, radiculitis of the upper extremities, right shoulder impingement and headaches. Treatment to date has included medications and radiological studies. The most current documentation in regards to the injured workers low back pain is dated July 17, 2014 and notes that the injured worker complained of intermittent low back pain with radiation into the right lower extremity. The pain was rated an eight out of ten on the Visual Analogue Scale. Physical examination of the lumbar spine revealed tenderness and a decreased and painful range of motion. A straight leg raise test was positive bilaterally. Sensation was noted to be diminished in the lumbar five-sacral one nerve root distributions and left foot. Current requested treatment is for Percocet 10/325 mg #100.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prospective: Percocet 320mg x90, 1 refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation

[http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS\\_regulations/MTUS\\_ChronicPainmedicaltreatmentguidelines.dpf](http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_regulations/MTUS_ChronicPainmedicaltreatmentguidelines.dpf).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) 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 indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Percocet (oxycodone/acetaminophen) is not medically necessary.