

<b>Case Number:</b>	CM15-0084590		
<b>Date Assigned:</b>	05/06/2015	<b>Date of Injury:</b>	05/05/2003
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/04/2015

### 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: North Carolina

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 48-year-old female, who sustained an industrial injury on 5/05/2003, due to cumulative trauma. The injured worker was diagnosed as having status post right carpal tunnel release, right ankle internal derangement, status post right ankle arthroscopic debridement, cervical facet arthrosis, cervical and lumbar discogenic disease, chronic cervical sprain/strain, chronic low back pain, status post right shoulder open decompressive surgery, bilateral knee internal derangement (right greater than left), bilateral chronic knee sprain/strain, history of TMJ (temporomandibular joint) syndrome, and dorsal spine sprain/strain. Treatment to date has included diagnostics, trigger point injections, epidural steroid injections, chiropractic, acupuncture, physical therapy, and medications. Currently (3/26/2015), the injured worker complains of continued pain in her low back, neck, and leg. Pain was not rated. Right lower extremity radicular pain was documented, S1 distribution, and neck pain, with primarily mechanical/axial pain. Her work status was total temporary disability and she was awaiting a cervical spine facet block. Exam of the cervical spine noted spasm, pain, and decreased range of motion, with facet and moderate neck tenderness. Exam of the shoulders noted positive impingement sign bilaterally and painful range of motion. Exam of the right knee noted tenderness to palpation along the joint line and positive McMurray's sign. Exam of the lumbar spine noted spasm, painful and limited range of motion, trigger points, positive straight leg raise test on the right, and increased right leg numbness. The treatment plan included Percocet, Anaprox, and Prilosec. Narcotic contract was updated. The PR2 report, dated 2/25/2015, noted reports of dizziness when taking medications (unspecified medications). Urine drug screen, dated

2/25/2015, was documented as inconsistent with prescribed medications, noting only prescribed medications documented as Tramadol and Gabapentin.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Percocet 10/325mg #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids  
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**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids (a) If the patient has returned to work. (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for

significant periods of time. There are no objective measures of improvement of function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.