

<b>Case Number:</b>	CM14-0152232		
<b>Date Assigned:</b>	09/29/2014	<b>Date of Injury:</b>	01/30/2009
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 66-year-old male who reported an injury of an unspecified mechanism on 01/30/2009. On 08/26/2014, his diagnoses included chronic low back pain, multilevel degenerative disc disease with disc herniations, facet arthropathy at L4-5, spondylolisthesis at L3-4, L4-5 and L5-S1, and diabetes mellitus. His complaints included a flare up of his low back pain and muscle spasms. He received a trigger point injection with no relief. He reported that his pain decreased and his function had improved with the use of his medications. Without them he reported having significant difficulty tolerating even routine activities of daily living. His medications included Oxaprozin 600 mg and Percocet 10/325 mg. He denied any negative side effects and there were no aberrant drug behaviors noted. Percocet was being prescribed for pain. A request for authorization dated 08/26/2014 was included in this worker's chart.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet tablets 10/325 MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-80, 92, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

**Decision rationale:** The request for Percocet tablets 10/325 mg #120 is not medically necessary. The California MTUS Guidelines recommend ongoing review of opioid use including documentation of pain relief, functional status, appropriate medication use, and side effects. It should include current pain and intensity of pain before and after taking the opioid. In most cases, analgesic treatment should begin with acetaminophen, aspirin, NSAIDs, antidepressants and/or anticonvulsants. There was no documentation in the submitted chart regarding appropriate long term monitoring/evaluations, including failed trials of aspirin, antidepressants, anticonvulsants or quantified efficacy. Additionally, there was no frequency specified in the request. Therefore, this request for Percocet tablets 10/325 mg #120 is not medically necessary.