

<b>Case Number:</b>	CM14-0181032		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	12/16/1990
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 and Rehabilitation, has a subspecialty in Pain Management 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:

This case involves a male patient with the date of injury of December 16, 1990. A Utilization Review dated October 17, 2014 recommended modification of 1 prescription of Percocet 10/325mg #150 to 1 prescription for Percocet 10mg/325mg #112 due to no evidence of objective measures of functional improvement. A Progress Report dated October 7, 2014 identifies interval changes of no change in the low back or radicular bilateral lower extremities (BLE) pain intensity or distribution. Medications prescribed are keeping the patient functional, allowing for increased mobility, and tolerance of activities of daily livings (ADL's) and home exercises. Objective findings identify tenderness to palpation L5-S1, TTP paraspinal; decreased range of motion; strength is decreased left lower extremities (LLE) and right lower extremities (RLE); and decreased sensation to pin left L3, Left L4, right L2, right L4, right L5, and right S1. Assessment identifies spasm of muscle, displacement lumbar disc W/O myelopathy, degenerated disc disease lumbar, stenosis lumbar spine, and lumbar radiculopathy. Plan identifies renew Percocet. The patient was warned of risks and encouraged to use drugs only as prescribed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #150:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 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 Percocet 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, medications are noted to improve the patient's function. There is a discussion regarding side effects and aberrant use. It is acknowledged that the documentation about analgesic efficacy and functional improvement is sparse. As such, the currently requested Percocet is medically necessary.