

<b>Case Number:</b>	CM14-0161484		
<b>Date Assigned:</b>	10/06/2014	<b>Date of Injury:</b>	10/13/2010
<b>Decision Date:</b>	05/27/2015	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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. 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: Iowa

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 38-year-old male, who sustained an industrial injury on 10/13/10. She reported low back pain, neck pain and right shoulder pain. The injured worker was diagnosed as having lumbar radiculopathy. Treatment to date has included multiple lumbar epidural steroid injections, physical therapy, home exercise program and acupuncture. Currently, the injured worker complains of constant low back pain with radiation to lower extremities with numbness and tingling pain is rated 9/10. Physical exam noted decreased lumbar range of motion. The treatment plan included prescription for omeprazole, Terocin patch, Percocet, Ambien, as well as administration of qualitative drug screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg #160:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Opioids Page(s): 78, 80-81, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Oxycodone Page(s): 74-96, 97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids.

**Decision rationale:** Percocet is an opioid class pain medication containing Oxycodone and acetaminophen. According to MTUS guidelines, opioids are indicated mainly for osteoarthritis only after first-line conservative options have failed, and should include clear improvement in pain and functional status for continued use. There is limited evidence to support long-term use for back or other musculoskeletal pain. MTUS also states that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur and an improved response to treatment should be observed. MTUS recommends discontinuing therapy if there is no improvement in pain or function. ODG does not recommend the use of opioids for musculoskeletal pain except for short use for severe cases, not to exceed two weeks. The medical documentation indicates the patient has been on this medication for a period of time exceeding the two-week recommendation for treatment length. There is no evidence of failure of first-line therapy or an indicated diagnosis. The treating physician has not provided rationale for the extended use of this medication, and does not include sufficient documentation regarding the reported pain over time or specific functional improvement while on this medication. The documentation indicates that the patient continues to have severe pain and decreased functional status with minimal improvement. The amount of medication to be distributed is also excessive. Therefore, the request for Percocet 10/325 mg #160 is not medically necessary at this time.