

<b>Case Number:</b>	CM15-0002582		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	07/28/1996
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2015

### 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: 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:

This 51 year old man reported left foot and back injuries dated 7/26/96. The mechanism of injury is not described in the available records except that there was a crush injury. Treatments to date have included multiple pain pumps with multiple complications, infections and surgeries; pain pump removal in 2006; oral and trans-dermal pain medications, oral steroids, and a home exercise program. The patient also has symptomatic non-industrial sarcoidosis. Current industrial diagnoses included chronic left foot, and leg pain with chronic regional pain syndrome from crush injury; and chronic low back pain with mild degenerative changes on MRI. Review of the available records reveals that this patient has been taking Percocet since least 1/3/14 in combination with either Duragesic patches or MS Contin. With time, the total dosage of opioids in terms of morphine equivalents has increased. The patient's functional level has not increased. He remains off work, and walks or goes to the gym "when he can". The primary treater documents that he is able to perform activities such as cooking, cleaning, self hygiene, writing songs, and building RC airplanes with his opioids, and unable to perform these activities without them. There is no documentation of his functional level prior to starting opioids. A 2/21/14 AME evaluation resulted in the evaluator sending the patient to the emergency room because of symptoms of drug withdrawal. The evaluator documented concerns about the patient's constantly changing medications and dosage, and noted that "he may be procuring medications from other sources". Also of concern is an inconsistent drug screen performed 9/18/14, which was positive for benzodiazepines. The clinical notes from that day and for several months prior did not list a benzodiazepine among the patient's medications, although Valium was listed

beginning 11/18/14. There is no comment on the inconsistency in the available records. A progress report dated 12/16/14 noted the injured worker presents with "ongoing low back pain and left lower extremity pain" and noted that "medications continue to bring his pain from a 10/10 down to a 7/10 allows him to be somewhat active." The treating physician, requested Percocet 10/325 mg #150, which is an increase from 4 to 5 per day. On 1/5/15, Utilization Review non-certified a request for Percocet 10/325 mg #150 and modified it to Percocet 10/325 mg #90 to allow for weaning. The MTUS, Chronic Pain Guidelines, Opioids, were cited.

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

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

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

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60; Criteria for use of Opioids, pages 76-77; Opioids for neur.

**Decision rationale:** Percocet 10/325 is brand-name oxycodone 10 mg with 325 mg acetaminophen. Oxycodone is an opioid analgesic. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific functional goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. If long-term opioids are used, a reassessment should be made at 6 months, and repeated every 6 months thereafter. The reassessment should include documentation of pain and function levels in comparison to baseline, an assessment of adverse side effects, and consideration of psychological consultation, and consideration of using a screening instrument for abuse/addiction. The clinical findings in this case do not demonstrate that any of the above guidelines have been followed. There is no documentation that Percocet was introduced individually, with ongoing careful assessment of function. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. Since this patient's primary diagnosis is chronic regional pain syndrome, it is likely that a major component of his pain is neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was made of whether or not opioid use was likely to be helpful in this patient, or of his potential for abuse. Comments by a concerned AME and an inconsistent drug screen did not even warrant a comment from the treating provider, let alone an assessment for abuse or addiction. No specific functional goals were set or followed. Most importantly, Percocet was not

discontinued when it became clear that it has not produced any functional improvement. There is no documentation of any improvement in this patient's level of function, and in fact his functional level appears to have decrease over the time that he has been taking Percocet. He remains off work, and now appears barely able to walk. This is more than adequate evidence that this patient is not responding appropriately to this medication, and that it should be discontinued. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review, Percoet 10/325 # 150 is not medically necessary for this patient. It is not medically necessary because of the lack of appropriate documentation of the patient's status prior to beginning it, because of the failure to set and monitor functional goals, because of the failure to evaluate for abuse or addiction, and because of the failure to discontinue it when it became clear that it has not produced any functional recovery.