

<b>Case Number:</b>	CM15-0101025		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	09/07/2013
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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: Physical Medicine & Rehabilitation, Pain Management

### 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 43 year old male injured worker suffered an industrial injury on 09/07/2013. The diagnoses included chronic pain, lumbar disc displacement, lumbar facet arthropathy and lumbar radiculopathy. The diagnostics included lumbar magnetic resonance imaging. The injured worker had been treated with epidural steroid injections and medications. On 4/28/2015, the treating provider reported constant low back pain that radiated down the left lower extremity greater than right, accompanied by numbness and tingling. The pain was 6/10 with medications and 9/10 without medications. On exam, there was tenderness and restricted range of motion to the lumbar spine along with positive left straight leg raise. The treatment plan included Percocet.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg (twice daily) Qty 60 (with the understanding that a specific treatment plan will be presented for the reduction and discontinuation of the opioid medication):**

Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs); Opioids Page(s): 16-19; 78-79.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid medication Page(s): 75-80.

**Decision rationale:** Regarding the request for Percocet (oxycodone/acetaminophen), Chronic 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, there is indication that the medication is improving the patient's function and pain as documented in a progress note from 4/28/2015. There is documentation of CUREs report from 11/25/2014 which showed no aberrant behaviors. Lastly, side effects of the medication were discussed extensively in the progress note from 4/28/2015. Therefore, the currently requested Percocet (oxycodone/acetaminophen) is medically necessary.