

<b>Case Number:</b>	CM15-0117529		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	10/28/2011
<b>Decision Date:</b>	07/28/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2015

### 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: 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 55-year-old male, who sustained an industrial injury on 10/28/2011. Diagnoses include cervical spine radiculitis with myofascitis, rule out cervical spine disc injury, chronic low back strain and sleep disturbance. Comorbid conditions include diabetes and obesity (BMI 37.9). Treatment to date has included diagnostics, lumbar epidural steroid injection, physical therapy, knee brace, knee viscosupplementation and medications. Per PR-2 dated 4/9/2015 the patient was taking Percocet which decreased the patients pain by at least 50% and sleep is difficult due to pain. Per the handwritten Primary Treating Physician's PR-2 dated 5/11/2015, the injured worker reported constant neck pain rated as 5/10 and decreased with ointment. There was more clicking in the left knee and pain was rated as 7/10. He also reported sharp pain to the left elbow with radiation to the fingers causing numbness. Sleep was limited to 5-6 hrs per night. Physical examination revealed an antalgic gait to the left with constant use of cane. There was a positive axial compression test on the right. He was temporarily totally disabled. The plan of care included medications and authorization was requested for Percocet 10/325mg #120.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80, 92, 124.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-9, Chronic Pain Treatment Guidelines Medications for chronic pain; Opioids Page(s): 60-1, 74-96.

**Decision rationale:** Oxycodone/APAP (Percocet) is a combination medication made up of the semisynthetic opioid, oxycodone, and acetaminophen, better known as tylenol. It is indicated for treatment of moderate to severe pain and is available in immediate release and controlled release forms. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day that is up to 60-120 mg/day of oxycodone depending on the formulation. If being used to treat neuropathic pain, then it is considered a second-line treatment (first-line are antidepressants and anticonvulsants), however, there are no long-term studies to suggest chronic use of opioids for neuropathic pain. If treating chronic low back pain, opioids effectiveness is limited to short-term pain relief (up to 16 weeks) as there is no evidence of long-term effectiveness. It is known that long-term use of opioids is associated with hyperalgesia and tolerance. According to the MTUS, opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. It is important to note, however, the maximum daily dose of opioids, calculated as morphine equivalent dosing from use of all opioid medications, is 120 mg per day. The major risks of opioid therapy are the development of addiction, overdose and death. The pain guidelines in the MTUS directly address opioid use by presenting a number of recommendations required for providers to document safe use of these medications. However, the provider has not documented the required monitoring tests and assessments for the safe use of chronic opioid therapy, specifically there are neither urine drug screens nor medical record notations of potential abuse or drug seeking behavior. There is also no documentation that trials of other first-line medications for neuropathic pain, such as antidepressants or antiepileptic, were attempted and failed nor documentation of a patient single-prescriber contract. The provider does document the effectiveness of the chronic opioid therapy and the calculated morphine equivalent dosage is 60 mg/day, which is well within the MTUS guidelines. Given all the above information, medical necessity for continued use of this medication has not been medically necessary.