

<b>Case Number:</b>	CM15-0120920		
<b>Date Assigned:</b>	07/02/2015	<b>Date of Injury:</b>	12/14/2007
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2015

### 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 injured worker is a 58 year old male, who sustained an industrial injury on 12/14/2007. He reported feeling a "pop" in the low back followed by feeling burning sensations and developing pain in bilateral shoulders. Diagnoses include lumbar disc herniation, sciatica, status post lumbar discectomy and bilateral shoulder impingement. Treatments to date include medication therapy, physical therapy, and acupuncture treatments. Currently, he complained of ongoing pain in the low back with radiation to bilateral lower extremities, neck, left knee, chest and TMJ. There was ongoing pain reported in the shoulder and bilateral upper extremities. Pain was rated 6/10 VAS with medication, and 8/10 VAS at worst. On 5/12/15, the physical examination documented multiple areas of tenderness and decreased range of motion. The plan of care included Endocet 10/325mg, one tablet every four hours #120.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Endocet 10/325 mg Qty 120, (1 tab every 4 hrs as needed, 30 day supply): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Opioids.

**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 Endocet, California Pain Medical Treatment Guidelines state that this 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 no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS) and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Endocet is not medically necessary.