

<b>Case Number:</b>	CM15-0178264		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	05/06/2013
<b>Decision Date:</b>	10/22/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2015

### 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: North Carolina

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:

The injured worker is a 50 year old female who sustained an industrial injury on 05-06-2013. The injured worker was diagnosed with low back pain, left lumbar spinal stenosis, lumbar radiculopathy, lumbar herniated nucleus pulposus and lumbar spondylolisthesis. The injured worker is status post lumbar laminectomy L3-4 and L4-5 in September 2014. According to the primary treating physician's progress report on July 14, 2015, the injured worker continues with unchanged symptoms of persistent lumbar spine pain and throbbing rated as 10 plus out of 10 on the pain scale. The injured worker reported associated pain radiating to both legs, left foot numbness, urinary incontinence, poor walking endurance, sleep difficulty and depression. Examination noted a left lower extremity antalgic gait. Romberg's test was negative with normal heel to toe gait, normal rapid alternating movements and sensation intact in all four extremities. Deep tendon reflexes were symmetric at the patella and Achilles. The injured worker ambulates with a cane. Musculoskeletal examination stated "with the exception of the lumbar spine, examination of the head, neck, spine and all four extremities reveals inspection and percussion within normal limits without tenderness or swelling and range of motion within normal limits without pain or crepitus". A recent lumbar spine magnetic resonance imaging (MRI) on March 3, 2015 with official report summary noted multi-level degenerative change including disc bulging which results in variable levels of lateral recess and bilateral neural foraminal encroachment and the degree of right sided neural foraminal encroachment at L3-4 has slightly increased from the prior examination (May 2014). Prior treatments documented to date also included surgery, physical therapy, epidural steroid injection, emergency room visits

(latest on 09-02-2015) for Percocet prescription and Toradol intramuscularly and medications. Current medications were listed as duplicates. They include Percocet 10mg-325mg, 1 by mouth every 4 hours as needed, Norco 10mg-325mg, 1 by mouth every 4 hours as needed, Valium 10mg, 1 by mouth every 6 hours as needed for spasms, Norco 10mg-325mg, 1 by mouth every 6-8 hours as needed for pain, Diazepam 10mg, 1 by mouth at bedtime as needed, Ondansetron 8mg twice a day as needed for nausea, Zofran 8mg (no directions), Diazepam 5mg, (no directions) and Hydrocodone 10mg-325mg, (no directions). There were no urine drug screenings available within the review. The Utilization Review recommended non certification of the request for Percocet 10mg-325mg #180 on 09-03-2015.

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

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

**Percocet 10/325mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of

opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function or how the medication improves activities. The work status is not mentioned. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.