

<b>Case Number:</b>	CM15-0078494		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	03/22/2013
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 53 year old male who sustained an industrial injury on 03/22/2013. Current diagnoses include lumbar radiculopathy with left foot drop, status post laminotomy and hemilaminectomy, left foraminal stenosis and recurrent foraminal stenosis with segmental collapse. Previous treatments included medication management, and back surgery. Previous diagnostic studies include an MRI's of the lumbar spine, EMG/NCS, and x-rays of the lumbar spine. Report dated 03/26/2015 noted that the injured worker presented with complaints that included left sided lower back pain with muscle spasms and pain in the left leg. Pain level was 8-9 out of 10 on the visual analog scale (VAS). Physical examination was positive for abnormal findings. The treatment plan included request for surgery and return in 6 weeks. Disputed treatments include Percocet.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 5/325mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

**Decision rationale:** Percocet 5/325mg #30 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation reveals that the patient has been on long term opioids without significant evidence of functional improvement or pain relief therefore the request for continued Percocet is not medically necessary.