

<b>Case Number:</b>	CM15-0091613		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	09/06/2001
<b>Decision Date:</b>	06/18/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2015

### 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: Emergency 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 50 year old male, who sustained an industrial injury on 09/06/2001. He has reported injury to the low back. The diagnoses have included lumbar radiculopathy; spondylosis with myelopathy lumbar region; post-laminectomy syndrome, lumbar; and myalgia and myositis. Treatment to date has included medications, diagnostics, transforaminal epidural steroid injection, lumbar medial branch blocks, dual lead spinal cord stimulator placement, and surgical intervention. Medications have included Percocet, Baclofen, and Celebrex. A progress note from the treating physician, dated 04/27/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of low back pain and bilateral lower extremity radiculopathy; pain level is rated as 7/10 on the visual analog scale with medications; and pain level is rated 8/10 on the visual analog scale without medications. Objective findings included some difficulty with transfers from sitting to standing; decreased lumbar range of motion for flexion and extension; and employment status is listed as full-time. The treatment plan has included the request for Percocet 10/325mg 30/month #120, refill 2 (90 days supply).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg 30/month #120 refill 2 (90 days supply): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain (chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-79.

**Decision rationale:** Percocet is acetaminophen and Oxycodone, an opioid. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation states that patient has been chronically on percocet with minimal improvement in pain or objective function. The number of tablets and refills requested is not appropriate. Percocet is a schedule 2 medication and does not allow for refills. Due to lack of documentation of any objective benefit in pain relief or improvement in function and inappropriate prescription, percocet is not medically necessary.