

Case Number:	CM13-0030186		
Date Assigned:	11/27/2013	Date of Injury:	10/13/2008
Decision Date:	01/17/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	09/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in physical medicine and rehabilitation, and is licensed to practice in New York and Texas. 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 physician 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/services.

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 patient is a 49-year-old who sustained a work related injury on 10/13/2008. The most recent progress report dated 12/03/2013 documented subjective complaints by the patient of continued cervical spine pain which radiated to the left shoulder and interfered with activities of daily living. The patient is noted to be status post fusion of C5-C6. Objective findings revealed limited range of motion of the cervical spine and increased myofascial tone to the paracervical musculature, left greater than right. The treatment plan included request for authorization for a refill of Percocet 5/325 mg and Xanax 1 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet, 5/325mg, 90 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines require certain criteria for ongoing monitoring of opioid use. Criteria include documentation of the 4 A's, (Adverse effects, Activities of daily living, Aberrant behaviors, and Analgesic efficacy), which are lacking in the documentation. The documentation indicates the patient has been utilizing the requested medication for over a year, but there is lack

of documentation submitted for review of functional benefit or satisfactory pain relief being achieved through the continued use of the requested medication. The request for Percocet, 5/325mg, 90 count, is not medically necessary or appropriate..

Protonix, 20mg, 60 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs)- GI (Gastrointestinal) Symptoms & Cardiovascular.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state that proton pump inhibitors are indicated for patients at risk for gastrointestinal events and/or cardiovascular disease and taking NSAIDs. The clinical information submitted for review failed to establish the patient was at risk for gastrointestinal events or cardiovascular disease. As such, the criteria have not been met. The request for Protonix, 20mg, 60 count, is not medically necessary or appropriate.