

Case Number:	CM13-0037055		
Date Assigned:	12/13/2013	Date of Injury:	03/03/2000
Decision Date:	02/05/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/22/2013

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 Pain Medicine and is licensed to practice in Ohio 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations

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 66-year-old female who reported an injury on 03/03/2000 due to cumulative trauma. The patient reportedly injured the bilateral hands, bilateral knees, chest/ribs, upper and lower back, and neck. The patient underwent an electrodiagnostic study that revealed L4-5 and L5-S1 chronic right radiculopathy. The patient's treatment history included medications, physical therapy, and epidural steroid injections. The patient's most recent clinical evaluation included a pain rating at 7/10. Physical findings included significant tenderness to palpation over the bilateral gluteus medius with 4 trigger points detected. The medications included Lidoderm 5% topical film, Ambien CR, Soma 350 mg, Percocet 10/325 mg, and Neurontin 300 mg. The patient's diagnoses included degenerative disc disease of the cervical spine, lumbar disc degeneration, and myofascial pain syndrome. The patient's treatment plan included continued medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet 10/325mg #240 Page(s): 89.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Pain Treatment Agreement Page(s): 78.

Decision rationale: The requested Percocet 10/325 mg #240 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of opioids in the management of a patient's chronic pain be supported by quantitative measurements to support pain relief, documentation of functional benefit, managed side effects, and evidence of monitoring for aberrant behavior. The clinical documentation submitted for review does not provide any evidence the patient has significant functional benefit or pain relief as result of this medication. Additionally, there is no documentation the patient is monitored regularly for aberrant behavior. Therefore, continued use would not be supported by guideline recommendations. As such, the requested Percocet 10/325 mg #240 is not medically necessary or appropriate.