

Case Number:	CM13-0066671		
Date Assigned:	01/03/2014	Date of Injury:	12/15/1999
Decision Date:	07/18/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	12/16/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Pennsylvania. 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/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 injured worker is a 49 year old male who reported an injury on 12/15/1999. The mechanism of injury is unknown. The injured worker complained of low back and lower extremity pain. The injured worker rated his pain at a 3-4/10 on a VAS scale. The injured worker was post right Transforaminal Epidural Steroid injection (TFESI) at L4-L5 and he reported 70% improvement in back symptoms. The injured worker also had 3 ankle surgeries in 2000, 2003 and 2006. The injured worker has diagnoses of low back pain, foot pain and lumbar disc with radiculitis. The injured worker has had TFESIs, Physical therapy and medications. The medications include Pravastin 40mg 1 tablet daily, Benazepril-Hydrochlorothiazide 1 tablet daily, Amlodipine 1 tablet daily and Percocet 10/325 mg 1-1 tablets 2 times a day PRN. There was a lack of documentation on any physical findings stating any functional deficits that were on going. There was also no evidence of subjective or objective findings. The treatment plan is for Percocet 10/325 Mg 1 To 1.5 Tab Tid Prn 3.5 Pills Day, 30, 105, Refills 0. The rationale for the request was not submitted for review. The request for authorization was submitted on 11/07/2013 by

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCOCET 10/325 MG 1 TO 1.5 TAB TID PRN 3.5 PILLS DAY, 30, 105, REFILLS 0:
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): 78, 80, 92.

Decision rationale: The request for Percocet 10/325 Mg 1 To 1.5 Tab Tid Prn 3.5 Pills Day, 30, 105, Refills 0 is not medically necessary. The injured worker complained of low back and lower extremity pain. The injured worker rated his pain at a 3-4/10 on a VAS scale. The California Medical Treatment Utilization Schedule (MTUS) guidelines state there is to be 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. The reports submitted did not show any of the above. There was no documentation rating the injured worker's pain before and after the Percocet. There was also no mention of side effects or how long the medication worked. The MTUS guidelines also state that there is to be the use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. The urinalysis submitted is not current, is dated 09/13/2013. Furthermore the guidelines do not recommend Percocet for the use of neuropathic pain; there are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant neuropathy. Given the above, the request for Percocet 10/325 Mg 1 To 1.5 Tab Tid Prn 3.5 Pills Day, 30, 105, Refills 0 is not medically necessary.