

Case Number:	CM14-0002330		
Date Assigned:	01/24/2014	Date of Injury:	10/11/2003
Decision Date:	06/23/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/07/2014

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 Pain Management, and is licensed to practice in 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 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 43-year-old female who reported an injury on 10/11/2003. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to the low back. The injured worker's chronic pain was managed with multiple medications to include Atarax, Lyrica, Elavil, Ambien, Percocet, and Zanaflex. The injured worker was examined on 12/17/2013. It was documented the injured worker had continued low back pain with no change in pain level or activity level. It was documented that the injured worker's pain medication was working well for the patient. Physical findings included restricted lumbar range of motion secondary to pain, palpable trigger points, and radiating pain with a twitch response in the lumbar paraspinal musculature. The injured worker had decreased sensation of the lateral and medial foot on the right side. The injured worker's diagnoses included hip pain, low back pain, and lumbosacral disc degeneration. The injured worker's treatment plan included trigger point injections, epidural steroid injections, and continued medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF PERCOCET 10/325MG, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested prescription of Percocet 10/325 mg #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review fails to provide a quantitative assessment of pain relief or documentation of functional benefit. Additionally, there is no documentation the injured worker is monitored for aberrant behavior. Furthermore, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested prescription of Percocet 10/325 mg #120 is not medically necessary or appropriate.