

<b>Case Number:</b>	CM14-0009661		
<b>Date Assigned:</b>	02/14/2014	<b>Date of Injury:</b>	06/26/2008
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	01/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/23/2014

### 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 and Rehabilitation 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 38 year old male who sustained an injury on 06/26/08 when he lost his balance twisting his left foot falling to the floor. The injured worker has been followed for continuing chronic low back pain. Prior treatment has included the use of physical therapy, medications, as well as epidural steroid injections. Despite this treatment, the injured worker has continued to report severe 10/10 low back pain. Prior medications have included Tramadol which did contribute to side effects. The injured worker has had prior Toradol injections for flare up of pain. Previous urinary drug screen results did note inconsistent findings for Hydrocodone as well as Hydromorphone. Further urinary drug screen findings again noted inconsistent findings regarding Codeine and Hydrocodone. The clinical report from 11/20/13 reviewed the injured worker's medications that include Alprazolam, Atarax, Soma, and Propranolol. The injured worker was receiving Norco and Xanax from other physicians. The injured worker indicated these medications provided pain relief which reduced emotional symptoms such as depression, anxiety, and sleep issues. The clinical report on 11/14/13 noted persistent low back pain 5/10 on the visual analog scale (VAS). Physical examination noted limited range of motion of the lumbar spine with positive straight leg raise findings bilaterally. The injured worker was recommended to continue with multiple topical medications for pain as well as Glucosamine, Somnicin, and other medical foods. A toxicology result from 11/21/13 noted inconsistent results for positive Soma. There were no positive findings for narcotics. The requested pain management follow ups for every 4-6 weeks as well as Percocet 10/325mg, quantity 75 were denied by utilization review on 01/08/14. It is noted that the pain management request was modified for one follow up in eight weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PAIN MANAGEMENT FOLLOW - UP VISIT EVERY 4-6 WEEKS:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-going Management.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 32.

**Decision rationale:** In regards to the request of for pain management follow ups every 4-6 weeks. The injured worker continues to be followed for chronic low back pain and has been prescribed multiple medications to address this pain. Given Independent Medical Examinations and Consultations Chapter ACOEM guidelines, the medications currently being requested for the injured worker, continuing pain management evaluations every 4-6 weeks is medically appropriate. Therefore, this request is medically necessary.

**PERCOCET 10-325 MG #75:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 88-89.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines Opioids. In regards to the requested Percocet 10/325mg, quantity 75. The clinical documentation provided for review noted several inconsistent drug screen reports which were not addressed in the clinical records. There is no indication that the patient was obtaining any substantial functional benefit from the use of short acting narcotics. Given and the inconsistent toxicology results and lack of clinical indication to continue the use of narcotics such as Percocet, the request for Percocet is not medically necessary.