

Case Number:	CM14-0013650		
Date Assigned:	02/26/2014	Date of Injury:	10/01/2003
Decision Date:	07/03/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/03/2014

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 58 year old male who reported an injury on 10/01/2003, secondary to an unknown mechanism of injury. The injured worker was evaluated on 12/13/2013 for reports of low back pain, increased with range of motion, with numbness in the bilateral lower extremities rated at 5/10. The injured worker also reported right knee pain increased with range of motion which was reported at 5/10. The exam noted an antalgic gait, palpable tenderness of the paravertebral muscles bilaterally, decreased sensation bilaterally in the L5 and S1 dermatomes. The range of motion was noted at 11 degrees extension, 15 degrees left lateral bend, and 14 degrees right lateral bend with absent reflexes at the knees and ankles bilaterally. A positive straight leg raise was noted to the right lower extremity. The exam of the knees indicated palpable tenderness over the medial joint line, over the medial fat pad, over the lateral joint line, and over the LCL bilaterally. The right-sided positive McMurray's test was noted. An unofficial CT scan from 10/17/2011 noted second degree spondylolisthesis at L5-S1. An unofficial MRI on 10/20/2011 noted a fusion and laminectomy at L3-S1, irregular fluid collection, and a moderate to severe spinal canal stenosis at L3-4, and severe spinal canal stenosis at L2-3. An unofficial EMG of the bilateral lower extremities on 01/09/2012 noted abnormal nerve conduction suggestive of sensory polyneuropathy secondary to diabetic condition and nerve palsy likely axonal in injury bilaterally; an abnormal electromyography was noted suggestive of bilateral chronic L5 radiculopathy. The diagnoses included right knee pain, status post removal of lumbar hardware, left leg radiculopathy, right foot drop, L3 through S1 degeneration, C6-7 stenosis, right C7-8 radiculopathy, L3-S1 stenosis and status post L3-S1 fusion. The treatment plan included physical therapy and placement of a spinal cord stimulator and implantable pulse generator. The request for authorization dated 01/21/2014 was found in the documentation provided. The rationale was not found in the documentation provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

OXYCONTIN 40 MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The MTUS Chronic Pain Guidelines recommend the use of opioids for ongoing management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug use behavior, and side effects. Furthermore, the frequency for the request is not provided. Therefore, based on the documentation provided, the request is not medically necessary and appropriate.

PERCOCET 10/325 MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The MTUS Chronic Pain Guidelines recommend the use opioids for ongoing management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use behavior, and side effects. Furthermore, the frequency for the request is not provided. Therefore, based on the documentation provided, the request is not medically necessary and appropriate.