

Case Number:	CM14-0114059		
Date Assigned:	08/01/2014	Date of Injury:	11/04/1996
Decision Date:	09/10/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/21/2014

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 Family Medicine, and is licensed to practice in California. 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:

This 52- year old bartender injured her low back lifting on 11/4/96. She has received extensive treatment including a lumbar laminectomy on 9/22/97, a lumbar fusion and laminectomy with instrumentation on 9/28/09, and implantation of a spinal cord stimulator on 11/17/11. Her primary physician has been treating her with trigger point injections and with multiple medications, which are dispensed from his office. These have included meloxicam and zolpidem since at least January 2014. Several muscle relaxants were dispensed during the same period including carisoprodol, tizanidine, and most recently cyclobenzaprine. Antidepressants during the same period included paroxetine and escitalopram. All available notes since 1/14 include references to ongoing acetaminophen with codeine, which has been dispensed at every office visit for which notes are available. A reference to Percocet occurs for the first time in a note dated 6/10/14, which states that the patient takes either Tylenol with codeine or Percocet for pain, depending upon how severe the pain is. The note states that she takes no more that two narcotic pills per day. There are no notes included in our records delineating why and when Percocet was started or whether any guidelines regarding opioid use are being followed. Apparently a request was made on 6/27/14 for #100 Percocet 10/325, which was denied in Utilization Review on 7/7/14. This progress note is not included in the available records. It is quite clear that this patient's clinical status has not changed despite the addition of Percocet to her multiple other medications. She remains "retired", which appears to be a euphemism for totally disabled. Her physician states that her medications allow her to do "ADLs" including household tasks, shopping and trips to the doctor, but he does not document any improvement in her ability to do them. He has documented no specific functional goals.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #100: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MEDICATIONS FOR CHRONIC PAIN; CRITERIA FOR USE OF OPIOIDS Page(s): 60; 76-77.

Decision rationale: Per the MTUS Guidelines cited above: Medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. Since the available records are incomplete, it is not clear if Percocet was started in conjunction with other medications. However, it is quite clear that it has not resulted in any functional improvement in this patient's case. Opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine in the patient's pain is nociceptive or neuropathic. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. None of these actions were documented in this case. Opioids should be discontinued if there is no improvement in function or a decrease in function. There has been no improvement in function in this case, and ongoing opioid use is not medically warranted.