

Case Number:	CM14-0151491		
Date Assigned:	09/19/2014	Date of Injury:	08/14/2004
Decision Date:	10/28/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/17/2014

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 Illinois. 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 48-year-old male who reported an injury on 08/14/2004 due to an unknown mechanism. The physical examination on 08/26/2014 revealed diagnoses of status post L5-S1 microdiscectomy with severe modic changes and edema in the disc space without evidence of discitis or osteomyelitis with normal ESR and CRP, status post L5-S1 anterior posterior fusion and decompression on 04/16/2014, and status post anterior lumbar interbody fusion. Medications were oxycodone, Prilosec, and Flexeril. The injured worker had complaints of constant low back pain rated a 9/10, which radiated to the bilateral lower extremities with associated numbness and tingling sensation to the bilateral legs down to the toes. The examination of the lumbar spine revealed paraspinal spasms and tenderness. There was a negative straight leg raise test. The motor examination was 5/5. The treatment plan was to continue medications as directed. The rationale was not submitted. The Request for Authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for Oxycodone/APAP 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain; Criteria for use of Opioids; Weaning of.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet, Ongoing Management, Page(s): page 75,86, page 78.

Decision rationale: The decision for 1 prescription of oxycodone/APAP 10/325 mg #60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend oxycodone/acetaminophen (Percocet) for moderate to severe chronic pain and that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. It further recommends that dosing of opioids not exceed 120 mg oral morphine equivalence per day, and for patients taking more than 1 opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. The 4 A's for ongoing monitoring of an opioid medication were not reported. The objective functional improvement was not reported for the injured worker. The request does not indicate a frequency for the medication. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

1 urine toxicology: 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 Ongoing Management, Page(s): page 78.

Decision rationale: The decision for 1 urine toxicology is not medically necessary. The California Medical Treatment Utilization Schedule indicates that the use of urine drug screening is for patients with documented issues of abuse, addiction, or poor pain control. It was not reported that the injured worker was having aberrant drug taking behavior. There were no other significant factors provided to justify 1 urine toxicology. Therefore, the request is not medically necessary.

1 adult diapers #100: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Durable Medical Equipment

Decision rationale: The decision for 1 adult diapers #100 is not medically necessary. The Official Disability Guidelines state that for durable medical equipment it is defined as equipment which can withstand repeated use, i.e., could normally be rented and used by successive patients, could primarily and customarily be used to serve a medical purpose, should generally not be useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. This request does not meet the term durable medical equipment. There were no other

significant factors provided to justify the decision for 1 adult diapers #100. Therefore, this request is not medically necessary.