

<b>Case Number:</b>	CM14-0155516		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	03/29/1998
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	09/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 & Rehabilitation & Pain 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:

The injured worker is a 55-year-old female who reported an injury on 03/29/1998. Mechanism of injury was not submitted for clinical review. Diagnoses included lumbar discogenic spine pain, hip pain, myofascial pain syndrome, failed back surgery syndrome, lumbar radiculopathy, degenerative disc disease, disorder rotator cuff, anxiety disorder, obesity and chronic pain. Previous treatments included medication. In the clinical note dated 08/19/2014, it was reported the injured worker complained of low back pain and lower extremity pain. She reported the pain was constant, sharp, dull and aching and throbbing. She rated her pain 8/10 in severity. Upon the physical examination the provider noted the injured worker had mild paraspinal tenderness to palpation. The lumbar spine revealed diffuse tenderness of the bilateral greater trochanter with tenderness to palpation. The sensation was mildly decreased in the bilateral lateral thigh. The provider requested Percocet, MS Contin. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**REMAINING PERCOCET 10-325MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 80-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management, Page(s): page(s) 78. .

**Decision rationale:** The request for remaining Percocet 10-325mg #60 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally the provider failed to document an adequate and complete pain assessment within the documentation. The use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

**REMAINING MS CONTIN 30MG #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 80-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management, Page(s): page(s) 78. .

**Decision rationale:** The request for the remaining MS Contin 30mg #30 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally the provider failed to document an adequate and complete pain assessment within the documentation. The use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.