

Case Number:	CM14-0177341		
Date Assigned:	10/30/2014	Date of Injury:	10/24/2013
Decision Date:	12/08/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/27/2014

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 Occupational 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:

Patient is 34 year-old male with date of injury 10/24/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 10/23/2014, lists subjective complaints low back pain. MRI of the lumbar spine (date not provided) was notable for multiple levels of degenerative disc disease with Schmorl's node in the superior endplate of L4 and degenerative disc disease family at the L2-3 level. Objective findings: No physical examination was documented. Diagnosis: 1. Lumbar spine pain 2. Thoracic spine degenerative disc disease. 3. Lumbar spine degenerative disc disease. 4. Thoracic spine spinal stenosis. 5. Lumbar spine spinal stenosis. The medical records supplied for review document that the patient has been taking the following medication for at least as far back as 10 months. Original reviewer modified medication request to Percocet 7.5/325, #28 with no refills. Medications: 1. Percocet 7.5/325mg, #45 SIG: 6 per day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 7.5/325 mg # 45 with one refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little functional improvement over the course of at least 10 months. Percocet 7.5/325 mg # 45 with one refill is not medically necessary.