

Case Number:	CM14-0179695		
Date Assigned:	11/04/2014	Date of Injury:	10/28/2010
Decision Date:	12/09/2014	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	10/29/2014

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 and 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 61-year-old male who reported an injury on 10/28/2010. The mechanism of injury was not submitted for review. The injured worker has diagnoses of post laminectomy syndrome, status post lumbar decompression from L2 to L5, spinal stenosis at L2-3 and L3-4, disc height virtually gone at L2-3, and depression and anxiety due to chronic pain. Past medical treatment consists of surgery, physical therapy, and medication therapy. Medications include Percocet 10/325, Ambien 5 mg, and Lexapro 10 mg. There were no urinalysis or drug screens submitted for review. The injured worker has undergone CT scans and MRIs. On 10/29/2014, the injured worker complained of persistent left lower extremity pain. Physical examination noted positive straight leg raise on the left side. The injured worker had no sensory changes in the anterolateral thigh and pre-tibial area. There was no evidence of atrophy or limping noted on gait. The medical treatment plan was for the injured worker to continue working part time and using medication therapy. The rationale Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg, eighty counts: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 89.

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

Decision rationale: The request for Percocet 10/325 mg with a count of 80 is not medically necessary. According to California MTUS Guidelines, they recommend Percocet for moderate to severe chronic pain and that there should be documentation of the 4 A's for ongoing monitoring. The submitted documentation lacked any indication of the 4 A's to include analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The submitted documentation also lacked the efficacy of the medication, nor did it indicate that it was helping with any functional deficits the injured worker might have had. There was no assessment submitted for review indicating what pain levels were before, during, and after medication administration. Furthermore, the request as submitted did not indicate a frequency of duration of the medication. Given the above, the injured worker is not within the MTUS recommended guideline criteria. As such, the request is not medically necessary.