

Case Number:	CM14-0192231		
Date Assigned:	11/25/2014	Date of Injury:	10/15/2011
Decision Date:	01/13/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/17/2014

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 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:

The patient is a 57 year-old male with date of injury on 10/15/2011. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 10/15/2014, lists subjective complaints as pain in the lower back with radicular symptoms to the right lower extremity. Objective findings on examination of the lumbar spine revealed tenderness to palpation of the paraspinal muscles. Range of motion was restricted in all directions. Lumbar discogenic provocative maneuvers, including pelvic rock and sustained hip flexion, were positive. Muscle strength was 5/5 in the bilateral lower extremities. Sensation was decreased in the L5 dermatome. Diagnosis: 1. Right L5 radiculopathy 2. Lumbar post-laminectomy syndrome 3. L5-S1 fusion 4. Failed back surgery syndrome 5. Lumbar disc protrusion. Original reviewer modified medication request to Percocet 5/325mg, #90 for weaning purposes and Senekot #60. The medical records supplied for review document that the patient has been taking Norco for at least as far back as eight months. The patient was prescribed Senekot on 10/15/2014, having received samples for three months prior. Medication: 1. Percocet 5/325mg, #120 SIG: q.i.d.2. Senekot, #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Short Acting Opioids), Criteria for Use.

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

Decision rationale: A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. 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 the last 8 months. Percocet 5/325 mg #120 is not medically necessary.

Senekot #90 (1 refill): 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 Page(s): 77.

Decision rationale: The Chronic Pain Medical Treatment Guidelines makes provision for the prophylactic treatment of constipation secondary to chronic opiate use; however, the patient was previously provided with a sufficient quantity of narcotics to be weaned from opioids which makes a laxative not medically necessary. Senekot #90 (1 refill) is not medically necessary.

Fluoroscopically guided percutaneous spinal cord stimulator trial: 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 Page(s): 105-107.

Decision rationale: According to the MTUS, indications for spinal cord stimulator are failed back syndrome, complex regional pain syndrome, post amputation pain, post herpetic neuralgia, spinal cord injury, pain associated with multiple sclerosis, and peripheral vascular disease. In addition, psychological screening should be obtained prior to a spinal cord stimulator trial, especially for serious conditions such as severe depression or schizophrenia. There is no documentation of a psychological screening. Fluoroscopically guided percutaneous spinal cord stimulator trial is not medically necessary.