

Case Number:	CM14-0050401		
Date Assigned:	06/25/2014	Date of Injury:	08/08/2002
Decision Date:	07/22/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/24/2014

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 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 60-year-old female who reported injury on 08/08/2002. The mechanism of injury was not provided within the documentation available for review. The injured worker presented with left lower back pain and left neck pain. Upon physical examination, the physician indicated the injured worker presented with muscle atrophy of the left arm, numbness of the left 4th and 5th fingers, muscle atrophy in the left thigh and calf, and numbness in the toes of the left foot. The cervical range of motion exam revealed stiffness with range of motion and negative straight leg raise bilaterally. According to the documentation provided, the injured worker underwent a left lumbar radiofrequency treatment of the L4-5 and L5-S1 facet joints on 02/03/2014, the results of which were not provided within the documentation available for review. Information about previous physical therapy and conservative care was not provided within the documentation available for review. According to the clinical information, the injured worker had been utilizing Norco prior to 07/10/2012. The diagnoses include cervical radiculopathy, cervical spondylosis with myelopathy, lumbar herniated disc L5-S1 and L4-5, and impingement/rotator cuff tendonitis. The injured worker's medication regimen includes Percocet and Tizanidine. The Request for Authorization for Percocet 10/325 mg, #180 was not submitted. The rationale for the request was not provided within the documentation available 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, #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids - Percocet, and Opioids - On-going Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines indicate the on-going management of opioids should include the on-going review and documentation of pain relief, functional status, appropriate medication use, and side effects. Satisfactory response to treatment may be indicated by the injured worker's decreased pain, increased level of function, or improved quality of life. According to the clinical documentation provided for review, the injured worker has utilized Percocet prior to 07/10/2012. The clinical note dated 07/11/2012 indicated the injured worker's pain was rated at 4/10. The injured worker's pain was rated at 3/10 on 01/10/2013. The clinical note dated 02/24/2014 indicated the injured worker rated her pain at 7/10. The clinical information provided for review lacks documentation related to the therapeutic and functional benefit from the long term utilization of Percocet. There was a lack of on-going review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, the request as submitted failed to provide frequency and directions for use. Therefore, this request for Percocet 10/325 mg, #180 is not medically necessary or appropriate.