

Case Number:	CM14-0064178		
Date Assigned:	07/11/2014	Date of Injury:	06/18/2008
Decision Date:	09/17/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/07/2014

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 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 36-year-old male who reported an injury on 06/16/2008. The mechanism of injury was not provided. The injured worker reportedly sustained an injury to his low back. The injured worker's treatment history included medications and physical therapy. The injured worker underwent an MRI on 02/22/2014 that documented that there were multilevel degenerative changes to the lumbar spine resulting in severe spinal canal stenosis at the L3-4 and right lateral recess effacement at the L3-4. The injured worker was evaluated on 04/18/2014. It was documented that the injured worker had continued increasing pain complaints rated at a 6/10 to 7/10. The injured worker's medications included Percocet 10/325 mg, Subsys 200 mcg/unit, and Pennsaid cream 2% was initiated. Physical examination findings included limited range of motion secondary to pain with tenderness to palpation of the lumbar facets and a positive straight leg raising test bilaterally. The injured worker's diagnoses included degenerative disc disease of the lumbar spine, lumbosacral radiculitis, sciatica, lumbago, and lumbosacral spondylosis without myelopathy. The injured worker's treatment plan included a refill of Percocet and initiation of the use of Pennsaid cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #120: 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 Opioids, On-Going Management Page(s): 111.

Decision rationale: The requested Percocet 10/325 mg #120 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends ongoing use of opioids in the management of chronic pain is supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of time. However, there is no quantitative assessment of pain relief to support continued use. Additionally, there is no documentation of functional benefit or that the injured worker is monitored for aberrant behavior. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Percocet 10/325 mg #120 is not medically necessary or appropriate.

Pennsaid 2% #2 bottles: 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 Topical Analgesics Page(s): 111.

Decision rationale: The requested Pennsaid 2% #2 bottles are not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend topical non-steroidal anti-inflammatory drugs for spine-related pain. The clinical documentation submitted for review does support that the injured worker's main pain generator is the lumbar spine. Therefore, the use of this medication would not be supported. Additionally, the California Medical Treatment Utilization Schedule does not recommend the long-term use of topical anti-inflammatory creams. The requested 2 bottles would be considered excessive. Furthermore, the request as it is submitted does not clearly identify an applicable body part. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Pennsaid 2% #2 bottles are not medically necessary or appropriate.