

Case Number:	CM14-0069153		
Date Assigned:	07/14/2014	Date of Injury:	11/04/1998
Decision Date:	09/17/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/14/2014

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 Nevada. 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 57-year-old male injured on 11/04/98 due to an undisclosed mechanism of injury. Diagnoses include cervical pain, cervical spondylosis, and post-cervical laminectomy syndrome. The clinical note dated 04/24/14 indicated the injured worker presented complaining of neck pain rated at 5/10 with the use of medication and 10/10 without medication use. The injured worker also complained of poor sleep quality and no change in activity level. The injured worker reported sufficient medication amount to treat pain levels and was looking forward to psychological treatment. Physical examination revealed motor testing limited by pain, grip 4/5 bilaterally, sensation intact throughout; cervical spine range of motion restricted with pain, paravertebral muscles normal, Spurling's maneuver produced no pain or radicular symptoms, and upper extremity reflexes equal and symmetric. Medications included Oxycontin 80mg 2 tabs TID, Percocet 10/325mg BID, Paxil 40mg QD, and Trazadone 50mg QHS. The initial request was non-certified on 05/05/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 80mg #180 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids: Overall Classification; Opioid Classifications; Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC]; Criteria for use of opioids;.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, Oxycontin 80mg #180 with one refill is not medically necessary and appropriate at this time.

Percocet 10/325mg #60 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids: Overall Classification; Opioid Classifications; Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC]; Criteria for use of opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, Percocet 10/325mg #60 with one refill is not medically necessary and appropriate at this time.