

Case Number:	CM14-0069387		
Date Assigned:	09/05/2014	Date of Injury:	05/16/2001
Decision Date:	11/21/2014	UR Denial Date:	04/23/2014
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 & 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 67-year-old male who reported an injury on 05/16/2001. The mechanism of injury was not submitted for review. The injured worker had a diagnosis of sacroiliac spine strain, lumbago, lumbar degenerative disc disease, and lumbar facet arthropathy. Past medical treatment consisted of injections, physical therapy, and medication therapy. Medications included Percocet, stool softeners, OxyContin, Nabumetone, Gabapentin, and Zanaflex. No diagnostics were submitted for review. On 04/08/2014, the injured worker complained of lumbar back pain. The physical examination lacked any pertinent evidence of range of motion, motor strength, or sensory deficits. The treatment plan was for the injured worker to continue medication therapy. The rationale was not submitted for review. The Request for Authorization form was submitted on 04/15/2014.

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: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77 and 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

Decision rationale: The request for Percocet 10/325mg #120 is not medically necessary. The submitted documentation did not provide the efficacy of the medication, nor did it indicate that the medication was helping with any functional deficits the injured worker might be having. Additionally, there was no assessment submitted indicating what pain levels were before, during and after medication administration. Furthermore, there were no UA's or drug screens submitted showing that the injured worker was compliant with prescription medications. Given the above, the injured worker is not within recommended criteria per the referenced guidelines. As such, the request is not medically necessary.