

Case Number:	CM14-0097146		
Date Assigned:	07/28/2014	Date of Injury:	02/20/1997
Decision Date:	09/10/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	06/25/2014

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 61-year-old male with a reported date of injury on 02/20/1997. The mechanism of injury was not submitted within the medical records. His diagnoses were noted to include lumbar radiculopathy, lumbar facet arthropathy, lumbar sprain/strain and lumbar degenerative disc disease. His previous treatments were noted to include medications and physical therapy. The progress note dated 06/03/2014 revealed the injured worker complained of chronic left lumbar axial and radicular pain. The physical examination revealed tenderness and palpation to the L4-5 and severe bilateral lumbar tenderness. The lumbar range of motion was diminished and there was positive straight leg raise testing. There was spasming noted to the bilateral lumbar region and decreased left lower extremity strength. The sensory examination revealed decreased bilateral lower extremity. The injured worker indicated he had functional pain control with the medication. The Request for Authorization form dated 07/08/2014 was for Percocet 10/325 mg #180 for pain.

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.

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

Decision rationale: The request for Percocet 10/325 mg #180 is non-certified. The injured worker has been utilizing this medication since at least 11/2013. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use and side effects. The guidelines also state that the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors should be addressed. There is lack of documentation regarding evidence of decreased pain on numerical scale with the use of medications. The injured worker indicated he had functional improvement from the utilization of his medication. There is lack of documentation regarding side effects or if the injured worker has had consistent urine drug screens and when the last test was performed. Therefore, due to the lack of documentation regarding significant pain relief, side effects and without details regarding urine drug testing to verify appropriate medication use and the absence of aberrant behaviors, the ongoing use of opioid medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. As such, the request is non-certified.