

Case Number:	CM14-0097475		
Date Assigned:	07/23/2014	Date of Injury:	08/09/2005
Decision Date:	09/11/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/12/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 51-year-old female who reported an injury on 08/09/2005. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar spondylolisthesis; status post fusion at L4-5 and L5-S1; reflex symptomatic sympathetic dystrophy, left leg; postoperative regional pain syndrome. The previous treatments included medication; surgery. Within the clinical note dated 03/14/2014, it was reported the injured worker complained of mid back and low back pain. She described her pain as frequent mild to moderate with stiffness. She complained of lower extremity pain which she described as constant, numbness and tingling pain. Upon the physical examination, the provider noted the injured worker to have 1+ to 2+ tenderness and muscle guarding bilaterally along the paravertebral and lower trapezius muscles. Upon examination of the lumbar spine, the provider noted 2+ tenderness along T8-T12 and L1-5. The range of motion was flexion at 35 degrees and extension at 15 degrees. The request submitted is for Percocet. However, a rationale was not provided for clinical review. The Request for Authorization is not provided for clinical review.

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 Opiates Page(s): 74-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: This is a request for Percocet 10/325 mg #120 to allow for the injured worker this 1 refill of Percocet for the purpose of weaning to discontinue with reduction of med by 10% to 20% per week over a weaning period of 2 to 3 months requested times 2 units. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provider failed to document an adequate and complete pain assessment. The request submitted failed to provide the frequency of the medication. The injured worker has been utilizing the medication since at least 09/2013. Therefore, the request is not medically necessary.