

Case Number:	CM14-0207058		
Date Assigned:	12/19/2014	Date of Injury:	02/17/2006
Decision Date:	02/13/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/10/2014

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 Family Practice, and is licensed to practice in Florida. 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 patient is a 37-year-old male with a date of injury of 12/17/2006. The mechanism of injury described is having lifted a heavy bag while loading a work truck. Diagnoses include: lumbar disc displacement, lumbar radiculopathy, chronic low back pain, and lumbar post-laminectomy syndrome. Prior treatment has included therapy, medications (including high doses of narcotics,) and surgery. He is status post a June 6th 2012 lumbar microdisectomy at the bilateral L3-L4 level. A 12/10/2014 office note physical documented the following pertinent positives: lumbar spine on inspection reveals surgical scars and lumbar Velcro orthotic wrap brace. Range of motion is restricted with flexion limited to 35 degrees by pain, extension is limited to 20 degrees by pain, and lateral rotation to the left and right is limited by 10 degrees. On palpation, paravertebral muscle tenderness is noted. Straight leg raise test is positive on both sides when sitting at 65 degrees. Work status is described as permanent and stationary. A utilization review physician did not certify refills for this patient's chronic narcotic medications Oxycontin (90 tablets) and Percocet (150 tablets.) He noted that a 4/25/2014 urine drug screen showed inconsistent results. No further drugs screen since this time have even been provided. On this drug screen Oxycontin was noted detected, but methadone was detected (which the provider noted had been discontinued on the prior visit.) The utilization review physician has recommended weaning this patient's narcotics. Therefore, an independent medical review has been requested to determine the medical necessity of these medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 30mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of opioids Page(s): 110-115.

Decision rationale: In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if "(a) If the patient has returned to work, (b) If the patient has improved functioning and pain." MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is inadequate proof of decreased pain and increased function with pain medications. Furthermore records show inconsistent results on this patient's last drug screen. On a 4/25/14 drug screen Oxycontin was noted detected, but methadone was detected (which the provider noted had been discontinued on the prior visit.) This request for Oxycontin is not considered medically necessary.

Percocet 10/325mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 110-115.

Decision rationale: In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if "(a) If the patient has returned to work, (b) If the patient has improved functioning and pain." MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is inadequate proof of decreased pain and increased function with pain medications. Furthermore records show inconsistent results on this patient's last drug screen. On a 4/25/14 drug screen Oxycontin was noted detected, but methadone was detected (which the provider noted had been discontinued on the prior visit.) This request for Percocet is not considered medically necessary.