

Case Number:	CM15-0149528		
Date Assigned:	08/12/2015	Date of Injury:	04/25/2000
Decision Date:	09/09/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/31/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 sustained an industrial injury on 04-25-2000. Initial diagnoses and treatments are not available. Current diagnoses include lumbar spondylosis, thoracic or lumbosacral neuritis or radiculitis-unspecified, and cervical spondylosis without myelopathy. Diagnostic testing and treatment to date has included x-rays, MRI, steroid injections, lumbar surgery, physical therapy, and symptomatic medication management. Currently, the injured worker complains of aching, burning low back pain that radiates down his legs bilaterally. He rates his pain as a 10 on a scale of 0 to 10 without medications, and a 5 out of 10 with medication. In a progress note dated 06-22-15, the treating physician reports the injured worker is receiving the lowest effective dose of pain medication. The medication allows him to have better mobility with daily activities. His Patient Activity Report results were appropriate. Requested treatments include Percocet 5-325 #120. The injured worker's status is not addressed. Date of Utilization Review: 07-02-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325mg, #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Percocet, California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain without side effects and no evidence of aberrant use. In light of the above, the currently requested Percocet is medically necessary.