

Case Number:	CM15-0168237		
Date Assigned:	09/08/2015	Date of Injury:	10/31/1983
Decision Date:	10/14/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	08/26/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 59 year old male, who sustained an industrial injury on 10-31-83. Initial complaints were not reviewed. The injured worker was diagnosed as having lumbar degenerative disc disease; degeneration of lumbar or lumbosacral intervertebral disc; lumbar radiculopathy; GERD Barrett's Esophagus; knee pain; chronic pain syndrome; myalgia and myositis unspecified; thoracic or lumbosacral neuritis or radiculitis unspecified; lumbar facet joint pain; spasm of muscle. Treatment to date has included physical therapy; urine drug screening; medications. Diagnostics studies included MRI lumbar spine. Currently, the PR-2 notes dated 8-5-15 indicated the injured worker complains of chronic low back pain in the setting of lumbar degenerative disc disease. He presents on this day for his medication refills. He reports his pain is stable but constantly bothersome. His pain score is reported as 10 out of 10 without medications but 4 out of 10 with medications. He reports benefit of chronic pain medication maintenance regimen, activity restriction, and rest continue to keep pain within a manageable level to allow his to complete necessary activities of daily living such as walking, shopping, light household chores and clean his pool, light kitchen duties. He is no longer able to cut firewood. He is able to sleep 6-7 hours per night with his pain and sleeping medications. Without them, he reports, he would be bedbound. On physical examination, the provider documents the lumbar spine has mild tenderness with moderate palpation over the lumbosacral area. He has negative straight leg raise and negative Patrick's. Flexion is 20% restricted and unable to extend and lateral bending is 60% restricted to the left and unable to the right. His motor strength remains 5 out of 5 in all major muscle groups with deep tendon reflexes +1 bilaterally with no radiculopathy. The provider reviews a MRI of the left knee dated 5-10-05

noting it reveals "medial knee osteoarthritis of the lateral patellar cartilage." A cervical spine x-ray is reviewed (no date but remarks "several years ago") indicated "a fusion between C5, C6 with decreased ossification. Degenerative disease at C6-7 and facet joint arthropathy throughout." A MRI of the thoracic spine is documented by the provider (no date) revealing "protruding discs at T1-2 and disc protrusion at C3-4 causing moderate spinal stenosis." He then reviews an EMG-NCV study dated 9-20-12 conclusion that "indicates severe sensory, motor and peripheral polyneuropathy in the lower extremities bilaterally. There is an electrodiagnostic abnormality in the lower extremities bilaterally, left worse than right. This could reflect L5-S1 radiculopathy, nerve root irritation and -or right S1 radiculopathy and nerve root irritation." Request for Authorization is dated 8-5-15. Utilization Review letter is dated 8-20-15 and non-certification was for Percocet 10/325 mg, ninety count. The provider submits PR-2 notes that are dated as far back as 2-10-15 requesting authorization of this medication. The provider is requesting authorization of Percocet 10/325 mg, ninety count (acetaminophen and oxycodone).

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg, ninety count: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

Decision rationale: Percocet is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as first line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Percocet for several months in combination with Celebrex. There was no mention of Tylenol, or weaning failure. The continued and chronic use of Percocet is not medically necessary.