

Case Number:	CM15-0023229		
Date Assigned:	02/12/2015	Date of Injury:	05/06/1996
Decision Date:	03/25/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/09/2015

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: Georgia

Certification(s)/Specialty: Anesthesiology, 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 65 year old male, who sustained an industrial injury on 05/06/1996. On provider visit dated 01/08/2015 the injured worker has reported chest pain muscular, chronic low back pain and right knee pain. On examination of lumbar spine there was a decreased range of motion noted, tenderness of lumbar paravertebral area, positive spasms, and trigger points and bilateral quadratus lumborum. Left sided sciatic pain was noted and a positive straight leg raise. Right knee was noted to have crepitus with flexion and tenderness in the lateral aspect and a decreased range of motion. The diagnoses have included status post lumbar fusion, chronic low back pain, multilevel lumbar discogenic disease and right knee internal derangement. Treatment plan included injections and medications. On 01/23/2015 Utilization Review non-certified Percocet 10/325mg #180. The CA MTUS Chronic Pain Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going management, When to continue Opioids Page(s): 79-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 79.

Decision rationale: Percocet 10/325mg # 180 is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore the requested medication is not medically necessary.