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| Case Number: | CM15-0029582 | | |
| Date Assigned: | 02/23/2015 | Date of Injury: | 03/18/2001 |
| Decision Date: | 04/08/2015 | UR Denial Date: | 02/06/2015 |
| Priority: | Standard | Application Received: | 02/18/2015 |

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

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 50 year old male who sustained an industrial injury on 3/18/01. He currently complains of low back pain with radiation to the left lower extremity. His pain intensity is 8/10. His activities of daily living are limited. His medications are Ambien and Percocet. Diagnoses are displacement of lumbar disc; degeneration of lumbar intervertebral disc, low back pain. Treatments to date include epidural steroid injections, acupuncture. In the progress note dated 1/15/15 the injured worker complains of significant low back pain and the treating physician has requested Percocet 10/325 mg to be refilled. On 2/6/15 Utilization Review non-certified the request for Percocet 10/325 mg citing MTUS: Opioids.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of Percocet 10/325mg, #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
 CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient presents with low back pain radiating into the left lower extremity, rated 8/10. The request is for PRESCRIPTION OF PERCOCET 10/325 MG # 150. Based on the 01/15/15 progress report, patient's diagnosis include displacement int. disc, lumbar (primary), degeneration of lumbar intervertebral disc, and low back pain. Patient's medications per 12/18/14 progress report include Ambien and Percocet. Patient's work status is unspecified. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Treater does not provide a reason for the request. The request is for Percocet # 150. UR letter dated 02/06/15 has modified the request to # 70. Percocet has been included in patient's prescriptions from 02/07/14 and 01/15/15. In this case, treater has not discussed how Percocet reduces pain and significantly improves patient's activities of daily living; the four A's are not specifically addressed including discussions regarding aberrant drug behavior and specific ADL's, no UDS reports, etc. Given the lack of documentation as required by guidelines, the request IS NOT medically necessary.