

Case Number:	CM15-0031740		
Date Assigned:	02/25/2015	Date of Injury:	01/15/2002
Decision Date:	04/10/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	02/19/2015

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 55 year old male who sustained a work related injury to the lower back on January 15, 2002. There was no mechanism of injury documented. The injured worker underwent a decompression laminectomy in 2003 and a right knee arthroscopy on August 14, 2014. The injured worker was diagnosed with lumbar degenerative disc disease with radiculopathy, degenerative joint disease, chronic pain syndrome, sleep disturbance and morbid obesity. According to the primary treating physician's progress report on February 12, 2015 the patient reported gradual improvement in frequency and intensity of pain to left side of the back and hip and increased pain on the right side, hip and leg area. The injured worker ambulates with a limp on the left. Lumbar spine flexion was 20 degrees, extension 5 degrees and lateral flexion at 13 degrees. Slight decrease in sensation was noted in the left calf and pain with straight leg raise. Deep tendon reflexes 2+ in Achilles and absent in patella were noted. Current medications are listed as Soma, Zolpidem, Oxycodone, Gabapentin, Voltaren gel and Pennsaid topical, Omeprazole, Celebrex, Linzess and Lunesta. Treatment modalities consist of authorization for physical therapy and continued medication. The injured worker has received 3 epidural steroid injections (ESI) with beneficial results. The treating physician requested authorization for Percocet 10/325 1 orally TID #90. On February 18, 2015 the Utilization Review denied certification for Percocet 10/325 1 orally TID #90. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS), Chronic Pain Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 1 po TID #90: 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 2/18/15 Utilization Review letter states the Percocet 10/325mg, 1 po TID #90 requested on the 2/12/15 medical report was denied based on the prior UR. The prior review modified the request to allow the physician to provide documentation on functional improvement, drug screens, pain contract, and subjective and objective improvement. According to the 2/12/15 medical report, the patient had been managing back and hip pain with trigger point injections. He is still recovering from a right knee arthroscopy and attending PT. Pain can get as high as 8-9/10, but was currently 3-4/10. The prior report dated 1/12/15 states with the medications, "he noted slight decreased some days as well with the trigger point treatment." 8-months of medical records were reviewed from 6/6/14 through 2/12/15 for discussion of medication efficacy. MTUS Chronic Pain Medical Treatment Guidelines, page 88-89 for "Opioids, long-term assessment CRITERIA FOR USE OF OPIOIDS Long-term Users of Opioids [6-months or more]" provides the criteria "Document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." The available medical reports did not document pain or functional improvement compared to a baseline using a numerical scale or validated instrument. There was no reporting to suggest a satisfactory response with decreased pain or improved function or quality of life. The MTUS criteria for continued use of opioids for long-term has not been met. The continued use of Percocet 10/325mg, 1 po t.i.d. #90 IS NOT medically necessary.