

Case Number:	CM15-0060271		
Date Assigned:	04/06/2015	Date of Injury:	10/12/2013
Decision Date:	05/06/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	03/30/2015

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: New Jersey, New York
 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 43 year old male who sustained an industrial injury on 10/12/13. The mechanism of injury is unclear. He currently complains of pain in the thoracic region, numbness and tingling intermittently through the thoracic region into the buttocks and legs. He uses a walker or wheelchair for mobility. He had surgery 7/14 and is now much weaker. He has had several falls since surgery. His activities of daily living are severely limited. He is not making any significant progress. Medications are oxycodone, Valium, aspirin, hydrocodone-acetaminophen, omeprazole, cyclobenzaprine, naproxen, Neurontin, Percocet. Diagnoses include status post one level lumbar fusion at L5-S1 (7/14); cervical intervertebral disc disease; bilateral lumbar radiculitis/ radiculopathy; lumbar spine strain/ sprain; osteoarthritis; sciatica. Treatments to date include aqua therapy with no effect, medications. Diagnostics include MRI of the thoracic spine (3/5/15) showing thoracic disc extrusion at T7-8 with extruded fragment and electromyography (12/8/14) normal; x-ray of the lumbar spine (3/11/15). In the progress note dated 2/20/15 the treating provider's plan of care requests refill on Percocet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg quantity 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80; 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-79.

Decision rationale: The request is not medically necessary. The patient has been taking Percocet for back pain. The chart does not provide any recent quantifiable objective documentation of improvement in function with the use of Percocet. There were no urine drug screen results available in the chart. There are no drug contracts or long-term goals for treatment. The patient is on multiple forms of opioids. The 4 A's of ongoing monitoring were not adequately documented. There was no evidence of objective functional gains with the use of Percocet. Therefore, the request is considered not medically necessary.