

Case Number:	CM15-0089521		
Date Assigned:	05/13/2015	Date of Injury:	01/07/2013
Decision Date:	06/15/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	05/09/2015

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: 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 56-year-old male, who sustained an industrial injury on January 7, 2013. He reported falling from a scaffold that then fell on him, with complex injuries of the neck and low back complicated by a deep venous thrombosis event while hospitalized resulting in chronic venous stasis changes of the right leg. The injured worker was diagnosed as having left C8-T1 radiculopathy, T1-T2 disc degeneration, prior C2-C6 anterior and posterior cervical decompression and fusion, L1-L2 disc degeneration, L1-L2 lumbar stenosis, prior L3 to s1 posterior lumbar decompression and fusion, chronic right C5, C6, C7, and C8 cervical radiculopathy, chronic left C6-C7 radiculopathy, severe left ulnar neuropathy at the wrist and elbow, left median neuropathy, morbid obesity, and hypertension. Treatment to date has included MRI, epidural steroid injection (ESI), CTs, abdominal ultrasound, x-rays, an Unna Boot, and medication. Currently, the injured worker complains of severe lower back pain, with his right hip "pops" and then radiates into the right thigh, and the right knee "pops" with his legs going out and falling four times since this had begun, with his hands constantly cold and numb. The Treating Physician's report dated April 7, 2015, noted the injured worker reported having 100% pain relief for two weeks following his last epidural steroid injection (ESI). The injured worker reported he used Percocet every six hours with this providing only four to five hours of pain relief, rating his pain on average at 10/10, and with medications at 5/10. The injured worker's current medications were listed as Coreg, Lisinopril, Lasik, Keflex, Xanax, Protonix, Percocet, and Aspirin. Physical examination was noted to show left lower extremity diffuse edema with cellulitic changes, without open wounds. The sensory examination was noted to show decreased

light touch and pinprick in the C8 and T1 dermatomes bilaterally. The injured worker's walking gait was noted to be antalgic with a front wheeled walker. The treatment plan was noted to include requests for authorization for Percocet, an urgent referral to an orthopedic specialist for evaluation of the right hip, and a MRI of the right hip.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioid, including Percocet. These guidelines have established criteria on the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Pain assessment should include: current pain, the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There should be evidence of documentation of the "4 A's for Ongoing Monitoring." These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. There is insufficient documentation of the "4 A's for Ongoing Monitoring." The treatment course of opioids in this patient has extended well beyond the time frame required for a reassessment of therapy. The records indicate that the patient has been simultaneously prescribed two short-acting opioids (Percocet and Dilaudid). There is no medical justification provided in records to support the need for two short-acting opioids. In summary, there is insufficient documentation to support the chronic use of an opioid in this patient. Treatment with Percocet is not considered as medically necessary.