

Case Number:	CM14-0121554		
Date Assigned:	09/16/2014	Date of Injury:	08/09/2007
Decision Date:	10/29/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	08/01/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 46 year old male injured on 08/09/07 when assaulted resulting in severe low back pain. The injured worker underwent lumbar surgery on 03/06/12 followed by spinal cord stimulator placement with ongoing lumbar pain. Clinical note dated 08/01/14 indicates the injured worker presented complaining of low back pain most severe in the midline of lower lumbar spine extending into the anterior, posterior and lateral aspect of the bilateral lower extremities to mid-calf level. Medications include Methadone 10 mg 1 tablet every 6 hours, Percocet 10/325 mg 1 tablet every 6 hours, and Robaxin 750 mg 1 tablet every 8 hours. The injured worker rated pain at 5/10. Physical examination revealed antalgic gait, marked tenderness in the midline of the lower lumbar spine, decreased lumbar range of motion, motor strength 5/5 in all muscle groups, reduced sensation to light touch in the medial right leg, straight leg raising test negative bilaterally, and negative Faber test bilaterally. The initial request was non-certified on 07/14/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg QTY:240: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As such, the request for Percocet 10/325mg QTY: 240 are not medically necessary.