

Case Number:	CM14-0092315		
Date Assigned:	09/12/2014	Date of Injury:	07/08/1993
Decision Date:	10/14/2014	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	06/18/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 50-year-old female reportedly injured her low back on 7/8/1993. The claimant underwent a lumbar fusion in 1999 followed by revision surgery in 2001. The most recent progress note, dated 5/20/2014, indicated that there were ongoing complaints of low back pain. Physical examination revealed paralumbar spasm with tenderness over the posterior facets at L2 to L5, sacroiliac joints, piriformis muscles and right greater trochanter. Lumbar spine range of motion was with flexion 40, extension 20 and lateral bending 30, and motor strength was 5/5 in lower extremities. No recent diagnostic imaging studies available for review. Previous treatment included lumbar spine surgery, lumbar epidural steroid injections, physical therapy, home exercises and medications, which included Gralise, Endocet, Soma, Gabapentin, Trazodone, Baclofen, Prevacid, Avinza and Percocet. A request had been made for Percocet 10/325 mg #180, which was not certified in the utilization review on 6/5/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 #180: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Goodman and Gilman's The Pharmacological Basis of Therapeutics, 12 Ed, McGraw Hill, 2006: Physicians Desk Reference,

68th Edition: [www .RXlist.com](http://www.RXlist.com): Official Disability Guidelines <http://www.odg-twc.com/odgtwc/formulary.htm>

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93.

Decision rationale: MTUS treatment guidelines support short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no clinical documentation of improvement in the pain or function with the current regimen. As such, this request is not considered medically necessary.