

Case Number:	CM15-0011113		
Date Assigned:	01/29/2015	Date of Injury:	01/05/1999
Decision Date:	03/25/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/21/2015

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 75-year-old male who reported an injury on 01/05/1999. The mechanism of injury was not specifically stated. The current diagnoses include lumbar postlaminectomy syndrome, status post L5-S1 interbody fusion in 09/2001, L5-S1 graded 2 to 3 spondylolisthesis, right lower extremity radiculopathy, coronary artery disease, status post myocardial infarction, reactionary depression/anxiety, low testosterone, bilateral shoulder myoligamentous injury, right clavicular fracture, and medication induced gastritis. The injured worker presented on 12/15/2014 with complaints of persistent low back pain radiating into the bilateral lower extremities. The current medication regimen includes Percocet 10/325 mg, Prilosec 20 mg, Remeron 15 mg, Prozac 20 mg, Ritalin 0.25 mg, and Klonopin 0.5 mg. Upon examination of the right shoulder, there was significant tenderness to palpation in the anterior and lateral subacromial bursa region with profound loss of motion. Examination of the left shoulder also revealed significant tenderness to palpation with profound loss of motion in abduction to 110 degrees. Examination of the lumbar spine revealed tenderness to palpation with muscle rigidity, numerous trigger points, and muscle guarding. There was normal range of motion of the lumbar spine with absent ankle jerks, and diminished motor strength in the bilateral lower extremities. Sensation was decreased in the posterolateral thigh and posterolateral calf bilaterally in the L5-S1 distribution. Straight leg raise was positive at 60 degrees bilaterally. Recommendations at that time included continuation of the current medication regimen. There was no request for authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone/Acetaminophen 10/325mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet (Oxycodone & Acetaminophen), Opioids, Criteria for Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines State a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. There is no documentation of objective functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. Given the above, the request is not medically appropriate at this time.