

Case Number:	CM15-0018467		
Date Assigned:	02/06/2015	Date of Injury:	02/15/1992
Decision Date:	03/31/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	01/30/2015

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: California
 Certification(s)/Specialty: Emergency Medicine

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 73 year old male, who sustained an industrial injury on 2/15/1992. The diagnoses have included lumbar post-laminectomy syndrome and cervical post-laminectomy syndrome. Treatment to date has included cervical radiofrequency ablation, lumbar epidural steroid injection (ESI) and medications. Surgical history included cervical fusion at C5-6 and lumbar fusion L2-L5. According to the visit note dated 1/8/2015, the injured worker had complaints of neck and lower back pain. With regards to ongoing neck pain, the injured worker continued to note benefit from cervical radiofrequency ablation done on 11/4/2014. Current neck pain was rated 3/10 on the visual analog scale (VAS). The injured worker noted that primarily axial back pain was exacerbated by extended periods of activity. He noted that with the use of Lidoderm patches, he was able to decrease his Percocet and was now only taking one tablet a day. He noted that Topamax helped significantly with the numbness and tingling that occurred at night. Objective findings included normal muscle tone and strength. Range of motion of the cervical spine was decreased. Authorization was requested for medications. The visit note dated 2/5/2015 documents that the injured worker was experiencing a dramatic increase in neck pain. He stated that his current pain was 6/10 and he was most bothered by radicular symptoms that occurred in his left upper extremity. On 1/23/2015, Utilization Review (UR) modified a request for Percocet 5/325mg #30 to Percocet 5/325mg #24. The Medical Treatment Utilization Schedule (MTUS) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325mg, #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications Page(s): 124.

Decision rationale: The request is for Percocet 5/325mg, #30, in order for the injured worker to take 1 tablet daily as needed for pain. Per the documents available for review, up until January 2015, the injured worker was utilizing 1 tablet of Percocet 5/325mg every 4-6 hours as needed for pain. The treating physician assistant began to taper the medication at that time due to significant relief of pain credited to use of lidocaine patches. Clearly the treating physician was beginning to taper the use of narcotic medication. Decreasing from 4-6 times per day down to once daily is a significant taper of narcotic medication. Per the MTUS guidelines for weaning of narcotic medications, weaning should be done slowly. Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal). A slower suggested taper is 10% every 2 to 4 weeks, slowing to a reduction of 5% once a dose of 1/3 of the initial dose is reached. Greater success may occur when the patient is switched to longer-acting opioids and then tapered. Office visits should occur on a weekly basis. The request as written falls within the guidelines for tapering of medications, and if anything is more rapid than suggested. Therefore, the request as written is supported by the MTUS and is medically necessary.