

Case Number:	CM15-0178629		
Date Assigned:	09/18/2015	Date of Injury:	10/25/2012
Decision Date:	10/28/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	09/10/2015

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: Texas, 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 10-25-2012. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for low back pain with a herniated disc at L4-5 and L5-S1 with instability, and lumbar strain. Medical records (06-03-2015 to 08-05-2015) indicate ongoing and worsening low back pain with pain and weakness in the bilateral lower extremities (left worse than right). Pain was rated 10 out of 10 without medications and 7 out of 10 with medications. Surgery was discussed and the IW agreed with the plan. Records also indicate that the IW's activity levels were worsening as he was now relying on a cane for stabilization and ambulation. Per the treating physician's progress report (PR), the IW has not returned to work. The physical exams, dated 07-15-2015 and 08-05-2015, revealed no changes in the physical exam findings as there continued to be decreased left ankle reflex, positive straight leg raise and bow-string test bilaterally, antalgic gait, positive lumbar tenderness, lumbar spasms, decreased lumbar range of motion by 50%, and inability to heel-walk or toe-walk. Relevant treatments have included physical therapy (PT), epidural steroid injections, injections (other), work restrictions, and pain medications (Percocet). The patient has had UDS on 6/3/15 that was negative for opioid and was consistent and was positive for cyclobenzaprine and Duloxetine and it was inconsistent. The request for authorization (08-05-2015) shows that the following medication was requested: Percocet 10-325mg #90. The original utilization review (08-13-2015) denied the request for Percocet 10-325mg #90. The patient has had MRI of the lumbar spine on 9/29/14 that revealed disc protrusions, foraminal narrowing, and degenerative changes. The medication list include

Percocet. Per the note dated 8/31/15 the physical examination of the lumbar spine revealed mild tenderness on palpation, muscle spasm, normal sensation and motor examination, decreased left ankle reflexes and normal gait. The patient's surgical history include lumbar fusion on 8/18/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Request Percocet 10/325mg #90. Percocet contains acetaminophen and oxycodone which is an opioid analgesic. According to CA MTUS guidelines cited below, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of the overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects..." In addition according to the cited guidelines "Short-acting opioids: also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain..." Per the notes, the pt had a positive straight leg raise and bow-string test bilaterally, antalgic gait, positive lumbar tenderness, lumbar spasms, decreased lumbar range of motion by 50%, and inability to heel-walk or toe-walk. The patient therefore had significant abnormal objective findings. The patient's surgical history included a lumbar fusion on 8/18/2015. There is no evidence of aberrant behavior. This medication is deemed medically appropriate and necessary in the present dose and amount to treat any exacerbations of the pain on an as needed/ prn basis. The medication Percocet 10/325mg #90 is medically necessary and appropriate in this patient.