MAXIMUS Federal Services

Case Number:	CM15-0178693		
Date Assigned:	09/18/2015	Date of Injury:	10/25/1999
Decision Date:	10/23/2015	UR Denial Date:	09/02/2015
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: 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 48 year old female who sustained an industrial injury on10-25-1999. Mechanism of injury was a slip and fall. Diagnoses include lumbar spine radiculopathy, failed back surgery and insomnia. A physician progress note dated 08-27-2015 documents the injured worker has continued complaints of low back pain and leg pain. She rates her pain without medication as 8 out of 10 and with medications as 5 out of 10. On 08-27-2015 she was having a flare-up of symptoms and she rated her pain as 8 out of 10. Her medications were reported to provide a 50% improvement in function and she was sleeping for 5 to 8 hours a night. It was documented that there was very little change from previous reports and she has continued decreased lumbar range of motion. In a physician note dated 07-23-2015 there is documentation the injured worker complains of continued low back pain and bilateral lower extremity pain. She rates her pain as 8 out of 10 without medications and 5 out of 10 with medications. Her medications allow for a 30-40% improvement in function and pain. She can walk, sit and stand longer and can sleep more restful at night. Range of motion remains restricted and painful. There is documentation present that the injured worker has been on Percocet since at least November of 2014 and at that time a determination was modifying the amount of Percocet from #180 to 90. In a Utilization Review dated 07-31-2015, Percocet 10-325mg #180 was modified to Percocet 10-325mg #30. Treatment to date has included diagnostic studies, medications, status post 11 back surgeries, cortisone injections, epidural injections, and therapy. She is not working. A computed tomography of the lumbosacral spine revealed status post anterior and posterior fusion at L4-L5 and there is pseudarthrosis across the disc interspace as well as posterior fusion mass. There is mild to moderate central canal stenosis and moderate bilateral foraminal stenosis. There is acute kyphosis at this level with a kyphotic angle of 13 degrees. She is not working. The Request for

Authorization dated 08-27-2015 included Restoril 30mg #30, Baclofen 20mg #90, Percocet 10-325mg #180, Embeda 30mg #30, and a follow up visit. On 09-02-2015 the Utilization Review non- certified the request for 1 MRI of the lumbar spine, and the request for Percocet 10/325 mg #180 was modified to Percocet 10-325mg #22.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies, Summary.

Decision rationale: As per ACOEM Guidelines, imaging studies should be ordered in event of "red flag" signs of symptoms, signs of new neurologic dysfunction, clarification of anatomy prior to invasive procedure or failure to progress in therapy program. Patient does not meet any of these criteria. There is no documented red flag findings in complaints or exam. There is no noted new neurologic dysfunction. Patient has had a CT already done on 3/15 that did not show any significant change. There is no justification documented for why MRI of lumbar spine was needed except "to rule out progression". MRI of lumbar spine is not medically necessary.

Percocet 10/325 mg #180: Upheld

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, Opioids for chronic pain, Opioids, long-term assessment.

Decision rationale: Percocet is acetaminophen and Oxycodone, an opioid. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails to provide any objective improvement in pain except for decrease in VAS. There is no objective improvement in functional status on current regiment. Provider has claimed "weaning" for several months with no noted decrease in opioid use. There is no documentation of any benefit from current Percocet use. Percocet is not medically necessary.