

Case Number:	CM15-0098541		
Date Assigned:	07/20/2015	Date of Injury:	12/31/2004
Decision Date:	08/14/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	05/21/2015

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: Arizona, 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:

This injured worker is a 61 year old male who reported an industrial injury on 12/31/2004. His diagnoses, and or impression, were noted to include: degenerative cervical and lumbar spondylosis and radiculitis; unilateral lumbar fusion pseudo-arthrosis; and status-post lumbar spine surgery (6/13/12); chronic pain syndrome; and depression secondary to chronic pain. No current imaging studies were noted. His treatments were noted to include: an agreed medical examination and report in 7/2010, with re-evaluations; 2 a comprehensive psychiatric evaluation and report on 8/1/2006, with re-evaluations; a complex neurological consultation and agreed medical examination on 10/21/2013; diagnostic sudomotor function assessment on 10/10/2014; medication management with toxicology screenings and notations regarding wean. The pain management progress notes of 1/9/2015 reported complaints which included moderate whole body pain, worse in the low back, with difficulty weight bearing on the left leg; of neck and upper back stiffness and pain; of popping in the left neck and ear; and of bilateral hand pain. He reported that his pain is severe without the benefit of his medications. Objective findings were noted to include: the use of a walker; tenderness and spasms of the cervical para-vertebral musculature with decreased cervical range-of-motion; positive paraesthesia; positive bilateral straight leg raise; and use of a lumbar support brace. The physician's requests for treatments were noted to include a functional restoration program and the continuation of Percocet at his usual dosage, and without the recommendation of weaning due to not meeting the criteria for weaning, and the benefit of having decreased pain resulting in the increased ability to participate in his self-care and activities of daily living.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-92.

Decision rationale: Percocet is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Percocet for a prolonged period without mention of Tylenol, NSAID or Tricyclic failure. The claimant had been on opioids for over 5 years. The continued and chronic use of Percocet at the maintained dose is not medically necessary.

1 Functional restoration program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program Page(s): 30-33.

Decision rationale: According to the guidelines, outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; and (6) Negative predictors of success above have been addressed. In this case, there is no clear documentation on surgical avoidance, willingness and agreement for motivation to change or forgo other gains. In addition, the claimant has undergone numerous evaluations and interventions as well as motor function testing. The request for an FRP is not medically necessary.

