

Case Number:	CM14-0150839		
Date Assigned:	09/23/2014	Date of Injury:	03/16/2004
Decision Date:	11/03/2014	UR Denial Date:	09/06/2014
Priority:	Standard	Application Received:	09/16/2014

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. The expert reviewer is Board Certified in Family Practice and is licensed to practice in Texas and Mississippi. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a 52-year-old male who reported an injury on 03/16/2014. The mechanism of injury involved repetitive lifting. Previous conservative treatment is noted to include medications, TENS therapy, and lumbar traction. Current diagnoses include chronic low back pain, lumbosacral radiculopathy, and lumbosacral disc injury. The current medication regimen includes Percocet 10/325 mg, Opana ER 20 mg, oxycodone 5 mg, and Flexeril 10 mg. The injured worker was evaluated on 06/03/2014 with complaints of persistent lower back and right lower extremity pain. Physical examination revealed no acute distress, tightness of the bilateral lumbosacral paraspinal muscles, and intact sensation. Treatment recommendations included continuation of the current medication regimen. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet tablets 10/325mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

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

Decision rationale: 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. As per the documentation submitted, the injured worker has continuously utilized this medication since 01/2014. The medical necessity for 3 separate opioid medications has not been established. There is no documentation of objective functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. As such, the request of Percocet tablets 10/325mg #150 is not medically necessary and appropriate.

Opana ER 20mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

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

Decision rationale: 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. As per the documentation submitted, the injured worker has continuously utilized this medication since 01/2014. The medical necessity for 3 separate opioid medications has not been established. There is no documentation of objective functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. As such, the request Opana ER 20mg #90 is not medically necessary and appropriate.

Oxycodone tablet 5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

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

Decision rationale: 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. As per the documentation submitted, the injured worker has continuously utilized this medication since 01/2014. The medical necessity for 3 separate opioid medications has not been established. There is no documentation of objective functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. As such, the request Oxycodone tablet 5mg #90 is not medically necessary and appropriate.

Physical therapy for flare up,#12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99..

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The injured worker has previously participated in physical therapy. There is no documentation of objective functional improvement. The injured worker is noted to be participating in a home exercise program. There is also no specific body part listed in the current request. As such, the request Physical therapy for flare up # 12 is not medically necessary and appropriate.