

Case Number:	CM14-0155335		
Date Assigned:	09/25/2014	Date of Injury:	09/30/2003
Decision Date:	11/03/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	09/22/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Ohio. 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 worker is a 32-year-old male who reported an injury on 09/30/2003. The mechanism of injury was not submitted for clinical review. The diagnoses included shoulder joint pain, hip joint pain, lower leg pain, lumbar degenerative disc disease, and sciatica. Previous treatments included medication, CT scan, physical therapy, chiropractic therapy, epidural steroid injections, and acupuncture. Within the clinical note dated 08/15/2014, it was reported the injured worker complained of right hip pain. He reported his hip was giving out/popping causing him to fall. He rated his pain 9/10 in severity. The injured worker reported having numbness, sharp, shooting and aching pain in the bilateral lower extremities radiating from the bilateral hips down to the feet. On the physical examination, the provider noted the injured worker had decreased range of motion of the back due to pain. There was positive facet loading in the bilateral L3-S1, pain with rotation, flexion and hyperextension. The right lower extremity was in a full leg brace. The provider requested Percocet. However, a rationale was not submitted for clinical review. The request for authorization was submitted and dated 08/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #210: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The request for Percocet 10/325 mg #210 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or patient treatment with issues of abuse, addiction or poor pain control. There is lack of documentation indicating the medication had been providing objective functional benefit and improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not submitted for clinical review.