

Case Number:	CM13-0045671		
Date Assigned:	12/27/2013	Date of Injury:	11/15/2007
Decision Date:	03/19/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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 physician 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:

This case involves a 53-year-old, right handed male, with an occupational injury on 11/15/07, after he injured himself lifting a 45 pound barrel. The current diagnoses include cervical spine musculoligamentous sprain/strain, L4/5 microdiscectomy and discectomy 01/14/11, bilateral lumbar radiculopathy, right hand overuse syndrome, left knee posttraumatic patellar synovitis, right shoulder high grade partial thickness articular surface tear with associated infrasubstance, depression and anxiety, insomnia, sexual dysfunction, and obstructive sleep apnea. The patient is unable to walk for more than five minutes without significant pain. His complaints include low back pain with radiation down the left lower extremity, left lower leg numbness, bilateral foot pain, right wrist pain, and right shoulder pain on elevation above the head. An MRI of the right elbow on 04/14/10 showed moderate to severe lateral epicondylitis with diffuse fraying of the proximal radial collateral ligament and proximal lateral ulnar collateral ligament. The right shoulder MRI on 10/26/11, after arthroscopic surgery, showed low grade partial thickness tear of the infraspinatus tendon and a low-to-moderate grade partial tear of the supscapularis tendon. An abnormal electromyography, dated 4/19/13 showed bilateral chronic active L5 radiculopathy, with a normal nerve conduction study. The patient has had L4/5 and L5/S1 transforaminal bilateral injections, which provided 65-70% alleviation of his radicular complaints. Repeat lumbar epidural steroid injections were recommended as was ongoing orthopedic follow-up. Prescription medications include Prevacid 30mg #30, Norco 10/325mg #120, one (1) tablet by mouth, Zanaflex 4mg #60, one (1) tablet by mouth twice a day, and Gabapentin 100mg #90, one (1) tablet by mouth three (3) times a day. He has been evaluated by pain management specialists. The patient's symptoms are refractory to physical therapy despite numerous sessions of arm and shoulder therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-96.

Decision rationale: The progress note on 09/30/13 indicated persistent pain in the neck and bilateral shoulders. The physical exam demonstrated cervical tenderness and restricted cervical range of motion, lumbar tenderness, and decreased sensation the lumbar spine. The treatment to date included medications, which included hydrocodone/acetaminophen, and had not helped. The medical doctor is requesting Percocet 10/325mg. The records indicated that there was no change in his symptoms despite the use of the Vicodin. The records indicated that the patient has been taking Vicodin for at least a year and the symptoms remained unchanged, therefore a addition of a second opioid is less likely to alter the course of the treatment with the excessive downside of addition and overdose. The Chronic Pain Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed and are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case there is little evidence of ongoing opioid management, including monitoring for diversion, abuse, side effects, or tolerance development; dosage adjustments, attempts to wean and taper, endpoints of treatment; and continued efficacy. Based on the above there is no indication that a second opioid would help or indicated.