MAXIMUS Federal Services

Case Number:	CM14-0067628		
Date Assigned:	07/11/2014	Date of Injury:	04/14/2008
Decision Date:	06/15/2015	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	05/12/2014

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. 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: Physical Medicine & Rehabilitation, Pain Management, Occupational 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 46 year old female, who sustained an industrial injury on April 14, 2008. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having chronic pain syndrome and thoracic outlet syndrome/brachial plexus lesions. Diagnostic studies to date have included MRI. Treatment to date has included physical therapy, spinal cord stimulator, trapezius injection, brachial plexus injections, transdermal opioid, oral opioid, topical pain, anti-epilepsy, antidepressant, psychostimulant, and non-steroidal anti-inflammatory. On March 30, 2015, the injured worker complains of chronic bilateral upper arm pain, greater on the right than the left. The pain is described as aching, burning, sharp, constant, buzzing, and vibrating. Associated symptoms include weakness, numbness, and tingling. Her stimulator is working well. She has used her opioid medication 3 times this week as she felt better with performing her own exercise and supplemental medications. The physical exam revealed a normal motor exam of the bilateral upper extremities. There was decreased sensation to pin prick of the right cervical 5, cervical 6, and cervical 8. There was allodynia of the hands, which was greater on the left than right. The treatment plan includes continuing her current medications included Ibuprofen, Percocet, and Restoril. The injured worker has been deemed permanent and stationary. The requested treatments are Percocet and Ritalin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

Decision rationale: MTUS 2009 states that opioid medications used to treat non-cancer pain should provide functional gains for individuals using them. The patient reportedly benefits from the use of the spinal cord stimulator and no longer requires the Percocet to treat pain on a scheduled basis. The patient does not appear to be dependent on the medication. The current dose prescribed is significantly less than this current prescription. The quantity and dose for the Percocet #120 significantly exceeds the reported need for analgesic medications at this time. Therefore, this request is not medically necessary.