

<b>Case Number:</b>	CM15-0132528		
<b>Date Assigned:</b>	07/20/2015	<b>Date of Injury:</b>	12/26/2014
<b>Decision Date:</b>	08/14/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2015

### 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:

The injured worker is a 35 year old male, who sustained an industrial injury on December 26, 2014. He reported pain to his neck and back. The injured worker was diagnosed as having neck strain with probable disc herniation and cervical radiculopathy, thoracic strain, lumbar strain with possible lumbar radiculopathy and post-concussion syndrome. Treatment to date has included diagnostic studies and medications. On June 8, 2015, the injured worker complained of bilateral low back pain radiating to the buttocks, right posterolateral thigh and calf pain, right foot pain, bilateral lower thoracic back pain and bilateral neck pain radiating to the shoulders. The treatment plan included an epidural steroid injection, facet joint medial branch block, follow-up visit and medication. On June 9, 2015, Utilization Review non-certified the request for Percocet 10/325 mg # 30 with no refills, citing California MTUS ACOEM.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #30 with no refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Percocet (Oxycodone).

**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 opioids for over 6 months. Pain scores were not routinely noted. Failure of Tylenol or NSAIDS was not noted. Percocet use is not justified and not medically necessary.