

Case Number:	CM15-0136977		
Date Assigned:	07/24/2015	Date of Injury:	09/12/2011
Decision Date:	08/21/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	07/14/2015

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 48 year old female who sustained an industrial/work injury on 9/12/11. She reported an initial complaint of neck, back, shoulder, and head pain. The injured worker was diagnosed as having rotator cuff syndrome, sprain of neck, sprain of shoulder and arm, sprain of lumbar region, cervical spondylosis. Treatment to date includes medication, surgery (anterior cervical discectomy and fusion at C3-4), physical therapy, epidural injection at bilateral L4-5 and L5-S1, and diagnostics. X-ray results were reported to demonstrate good alignment and position of the interbody graft. Currently, the injured worker complained of intermittent aching back pain for which she uses a walker. Per the primary physician's report (PR-2) on 7/9/15, exam notes use of a soft cervical collar and foam support under the right arm, patchy hypalgesia to pinprick in the long finger, left hand thumb on the right. Voice was hoarse. The requested treatments include Percocet 10/325mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, pain treatment agreement Page(s): 89.

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 Norco for several months. No one opioid is superior to another. There was no mention of Tylenol, NSAID, Tricyclic or weaning failure. The continued use of Percocet is not medically necessary.