

<b>Case Number:</b>	CM15-0144801		
<b>Date Assigned:</b>	08/05/2015	<b>Date of Injury:</b>	01/10/2013
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	07/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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: California, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 34 year old male, who sustained an industrial injury on January 10, 2013. He reported neck and right shoulder pain. The injured worker was diagnosed as having cervicobrachial syndrome, predominant disturbance of emotions, brachial plexus lesions, shoulder region pain in joint and cervicgia. Treatment to date has included diagnostic studies, surgery, H wave, physical therapy, medication and injection. On June 2, 2015, the injured worker complained of neck pain, neck stiffness, headaches, shoulder pain, radiating arm pain, arm and hand tingling with numbness and low back pain. Rest and medication were noted to relieve the pain. Aggravating factors included increased activity, turning his head and bending his neck. The injured worker reported greater than 50% relief with his current maintenance regimen allowing him an adequate level of functionality. He remains as functional as tolerated during the day. The treatment plan included consultation with an orthopedic surgeon, a follow-up visit and medication. On July 1, 2015, Utilization Review non-certified the request for Percocet 5 325mg #40 and massage therapy (no frequency or duration), citing California MTUS and Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 5/325mg #40:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** The patient presents with neck and right shoulder pain, headaches, lower back pain and right arm pain with paresthesia. The current request is for Percocet 5/325mg #40. The treating physician report dated 6/2/15 (30b) states, "Maintenance regimen consists of Tramadol, Tramadol ER, Xanax and Norco daily. This regimen allows him an adequate level of functionality". For chronic opiate use, the MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the treating physician has documented that the patient has greater than 50% pain relief with his current medications. There is documentation that the patient is able to care for himself, do dishes and function better during the day with medication usage. The physician states that there are no side effects or aberrant behaviors. The current request is medically necessary.

**Massage therapy (no frequency or duration):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter - Massage.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**Decision rationale:** The patient presents with neck and right shoulder pain, headaches, lower back pain and right arm pain with paresthesia. The current request is for Massage Therapy (No frequency or duration). The treating physician states that the patient requires orthopedic referral. The MTUS guidelines state that massage therapy is recommended as an option as an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. In this case, there is no documentation of any prior massage therapy visits and the current request does not specify a quantity of massage therapy visits that are being requested. MTUS does not support an unlimited number of massage therapy sessions. The current request is not medically necessary.