

<b>Case Number:</b>	CM15-0041541		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	12/24/2010
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	02/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2015

### 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: Texas, 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:

This is a 55 year old female patient, who sustained an industrial injury on 12/24/2010. She sustained the injury due to an assault. The diagnoses include left clavicular fracture - healed; left shoulder adhesive capsulitis; and left rotator cuff tear; cervical trap strain; and thoracic strain. A recent note dated 2/9/2014 was not fully legible. Per the note dated 2/9/2015, she had complaints of cervical pain with radiation to the upper extremities with tingling and numbness. The physical examination revealed tenderness and decreased range of motion of the cervical spine and positive Spurling test. The 11/21/2014 progress report is hand written and not fully legible, notes cervical spine and other complaints, and that she is temporarily totally disabled. The current medications list includes MS contin, prozac, klonopin, percocet. She has undergone bilateral knee arthroscopy. She has had diagnostic studies including cervical x-rays on 5/2/12; computed tomography scans of the cervical spine on 6/20/2012 which revealed spondylosis and small disc bulge at C3-4, C4-5 and C5-6; CT lumbar spine on 6/20/2012. She has had physical therapy yielding temporary relief; epidural steroid injection; home exercise program and detoxification program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 5/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids, specific drug list; Weaning of Medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-80.

**Decision rationale:** Request: Percocet 5/325mg #90. This is a request for Percocet, which is an opioid analgesic. It contains acetaminophen and oxycodone. According to CA MTUS guidelines cited above, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." The records provided did not specify that that patient has set goals regarding the use of opioid analgesic. A treatment failure with non-opioid analgesics was not specified in the records provided. Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. To aid in pain and functioning assessment, the patient should be requested to keep a pain dairy that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." The records provided did not provide a documentation of response in regards to pain control and objective functional improvement to opioid analgesic for this patient. The continued review of the overall situation with regard to non-opioid means of pain control was not documented in the records provided. As recommended by the cited guidelines a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these are not specified in the records provided. A recent urine drug screen report is not specified in the records provided. This patient does not meet criteria for ongoing continued use of opioids analgesic. The medical necessity of Percocet 5/325mg #90 is not established for this patient at this time. Therefore, the service is not medically necessary.

**CT scan of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Neck & Upper Back (updated 11/18/14)Computed tomography (CT).

**Decision rationale:** Request: CT scan of the cervical spine. Per the ACOEM chapter 8 guidelines for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. The ACOEM chapter 8 guidelines recommend MRI or CT to evaluate red-flag diagnoses as

above, MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. If no improvement after 1 month bone scans if tumor or infection possible, Not recommended: Imaging before 4 to 6 weeks in absence of red flags. Patient does not have any evidence of severe or progressive neurologic deficits that are specified in the records provided. She has had diagnostic studies including cervical x-rays on 5/2/12; computed tomography scans of the cervical spine on 6/20/2012 which revealed spondylosis and small disc bulge at C3-4, C4-5 and C5-6. Per the ODG guidelines "Repeat CT is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation where MRI is contraindicated). (Roberts, 2010)." Significant change in signs or symptoms since previous cervical CT scan that would require a repeat cervical spine CT scan is not specified in the records provided. Response to prior conservative therapy for this injury is not specified in the records provided. Previous conservative therapy notes are not specified in the records provided. Per the records provided, patient does not have any evidence of red flag signs such as possible fracture, infection, tumor or significant neurocompression. In addition a recent cervical spine X-ray report is also not specified in the records provided. The medical necessity of CT scan of the cervical spine is not established for this patient. Therefore, the service is not medically necessary.