

Case Number:	CM15-0129295		
Date Assigned:	07/15/2015	Date of Injury:	03/01/2010
Decision Date:	08/13/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	07/03/2015

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

Certification(s)/Specialty: Preventive Medicine, 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 58 year old female, who sustained an industrial injury on 3/01/2010. Diagnoses include cervicalgia, lumbago status post posterior lumbar interbody fusion, cubital tunnel syndrome and carpal tunnel syndrome. Treatment to date has included surgical intervention (L5 laminectomy, partial S1 laminectomy and L5-S1 posterior fusion (PLIF) on 12/05/2014) as well as postoperative physical therapy and medications including Norco, Gabapentin and Soma. Per the Primary Treating Physician's Progress Report dated 3/31/2015, the injured worker reported constant pain to the low back with radiation into the lower extremities. She rated her pain as 5/10 in severity. She also reported 7/10 bilateral elbow and wrist pain. Physical examination of the elbow revealed tenderness about the olecranon groove and medial epicondyle. Range of motion was full but painful. Wrist and hand evaluation revealed tenderness over the volar aspect of the wrist. There was full but painful range of motion. Lumbar spine evaluation revealed palpable paravertebral tenderness with spasm and guarded restricted ranges of motion. The plan of care included medications and authorization was requested for Percocet 10/325mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 #120 tablets (4 per day): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

Decision rationale: MTUS Guidelines support the careful use of opioid medications when specific criteria are met. The use of Percocet appears to meet the Guideline criteria for continued use. The Guideline standards include meaningful pain relief, functional benefits/support and the lack of persistent drug related aberrant behaviors. This individual is documented to have meaningful pain relief, improvement in ADL functioning and no drug related aberrant behaviors. Under these circumstances, the Percocet 10/325 #120 tablets (4 per day) are supported by Guidelines and are medically necessary.