

<b>Case Number:</b>	CM15-0079717		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	11/07/2003
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	04/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 48 year old male who sustained an industrial injury on 11/07/2003. Diagnoses includes status post re-due thoracic spinal cord stimulator trail 04/08/2014, L1 burst fracture, status post corpectomy and T12-L2 fusion in 2003, history of right calcaneal fracture with chronic regional chronic pain syndrome, history of left tibial plateau fracture, status post closed reduction and internal fixation with hardware removal, status post revision of pulse generator switching to [REDACTED] on 02/16/2015, and status post thoracic spinal cord stimulator, failed. Treatment to date has included diagnostic studies, medications, and physical therapy. A physician progress note dated 03/03/2015 documents the injured worker continues to have mid to lower back pain which radiates into the groin, rated as 3 on the Visual Analog Scale without medications, and 1 on medications. He continues to have severe right foot pain rated a 6-7 on the Visual analog Scale without medications and a 5-6 with medications. The treatment plan is for a referral to an ankle specialist for a consultation and treatment recommendations including possible surgery such as arthrodesis, and a follow up visit. Treatment requested is for Percocet 10/325 mg, ninety count.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg, ninety count: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 80 - 81.

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

**Decision rationale:** Guidelines recommend opioids for short term treatment of moderate to severe pain, with documented objective evidence of efficacy, functional benefit, lack of side effects and attempts to assess for aberrant use. In this case, there was no documented symptomatic or functional improvement from its previous usage and no compliance with risk assessment. The request for Percocet 10/325 mg #60 is not medically appropriate and necessary.