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| Case Number: | CM13-0066738 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 08/01/2010 |
| Decision Date: | 04/21/2014 | UR Denial Date: | 11/21/2013 |
| Priority: | Standard | Application Received: | 12/17/2013 |

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. The expert reviewer is Board Certified in Anesthesiology, Pain Management and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 42-year-old female who reported an injury on 08/01/2010 after boxes filled with metal fell on top of her. The patient reportedly sustained in injury to the left shoulder and arm. The patient's treatment history included physical therapy, aquatic therapy, cervical steroid injections, and left shoulder arthroscopic acromioplasty with subacromial decompression. The patient was treated postoperatively with immobilization, physical therapy, and a cryotherapy unit. The patient's most recent clinical evaluation documented that the patient had left shoulder range of motion described as 150 degrees in flexion and 15 degrees in extension with tenderness to palpation over the left deltoid. The patient's diagnoses included bursitis of the shoulder, and complete rupture of the rotator cuff. The patient's treatment plan included continuation of medications to include Percocet and a non-steroidal anti-inflammatory medication with continuation of physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg QTY: 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: The requested Percocet 10/325 mg quantity 120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior or has functional improvement related to medication usage. Additionally, the clinical documentation does not provide a quantitative assessment to support the efficacy of this medication in providing pain relief. As such, the requested Percocet 10/325 mg quantity 120 is not medically necessary or appropriate.

Ibuprofen 800mg QTY: 90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NSAID Overall Dosing Recommendation Page 70 Ibuprofen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs), Page(s): 60 and 67.

Decision rationale: The requested ibuprofen 800 mg quantity 90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of non-steroidal anti-inflammatory drugs in the management of chronic pain. However, California Medical Treatment Utilization Schedule recommends the continued use of this medication in the management of chronic pain be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review does not provide any specific evidence of functional benefit or pain relief resulting from the patient's medication usage. Therefore, continued use would not be supported. As such, the requested ibuprofen 800 mg quantity 90 is not medically necessary or appropriate.

Neurontin 300mg QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 17.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16 and 60.

Decision rationale: The requested Neurontin 300 mg quantity 30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of anticonvulsants as first line medications in the management of chronic pain. However, California Medical Treatment Utilization Schedule also recommends that patients using medications in the management of chronic pain have documentation of functional benefit and pain relief. The clinical documentation submitted for review does not provide any evidence that the patient receives any functional benefit or pain relief from the current medication schedule.

Therefore, continued use would not be supported. As such, the requested Neurontin 300 mg quantity 30 is not medically necessary or appropriate.