

Case Number:	CM14-0007421		
Date Assigned:	02/07/2014	Date of Injury:	11/28/2002
Decision Date:	06/20/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/16/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 61 year old male who sustained work related injuries 11/28/02. On that date he was reported to have been exiting his tractor trailer when he slipped and fell sustaining injuries to his left shoulder, neck, low back, and legs. The claimant ultimately underwent anterior L4-5 fusion. Imaging studies reportedly showed substantial disc herniation at C5-6. The claimant ultimately underwent a reverse total shoulder replacement of the left shoulder on 12/15/13. Per clinical note dated 12/31/13 he was reported to do poorly because his children took the medications on physical examination his wound was healing well with minimal ecchymosis. There was minimal lymphedema. His neurological examination was normal. There was no hematoma in the anterior shoulder and no signs of infection. Passive motion was approximately to 90 degrees of forward flexion and abduction. The injured worker was recommended to begin formal physical therapy twice a week for six weeks the record contained a utilization review determination dated 01/03/14 which non-certified the request for prescription of Percocet 5 325mg #180 and six sessions of acupuncture for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PRESCRIPTION FOR PERCOCET 5/325MG #180: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIATES
Page(s): 74-80.

Decision rationale: The request for Percocet 5/325 mg #180 is medically necessary. The injured worker is status post reverse total shoulder arthroplasty on 12/15/13. The injured worker requires post-operative analgesia during the immediate post-operative phase and during the rehabilitative phase due to the extensive nature of his surgery. As such this request would be consistent with the California Medical Treatment Schedule (CA MTUS) guidelines for the treatment of post-operative pain. The request is not medically necessary and appropriate.

SIX ACUPUNCTURE SESSION FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request is not supported as medically necessary. The injured worker has chronic history of low back pain. He has undergone extensive treatments in the past. The record does not provide a rationale for this recommendation. Therefore medical necessity has not been established.