

<b>Case Number:</b>	CM14-0190037		
<b>Date Assigned:</b>	11/21/2014	<b>Date of Injury:</b>	11/18/1999
<b>Decision Date:</b>	01/31/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2014

### 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 Physical Medicine Rehab, has a subspecialty in Pain Medicine and is licensed to practice in California. 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:

This is a male patient with a date of injury of November 18, 1999. A utilization review determination dated November 3, 2014 recommends non-certification of Percocet 5-325 mg #120 with modification to #45 for weaning purposes, Keflex 500 mg #12, Ambien 10 mg #30, and Zofran 4 mg #30. A progress note dated September 24, 2014 identifies subjective complaints of worsened bilateral shoulder pain, a pain level of 8/10 of the right shoulder, and a pain level of 8/10 of the left shoulder. Movement and colder weather increase the patient's pain, and he has difficulty sleeping at night, getting dressed, and showering due to his pain. The patient currently takes Percocet 10-325 mg up to 4-5 times a day, and he discontinued Ambien that he was receiving from his primary care physician. The physical examination of the right shoulder reveals a positive Neer's test, Hawkin's test, Yeargason's test, Cross arm test, and decreased sensation on the right C5-6. The physical examination of the left shoulder reveals a positive Neer's test and Hawkin's test. The diagnoses include bilateral shoulder rotator cuff tear status post rotator cuff repair, right shoulder hardware failure, right shoulder recurrent rotator cuff tear, left shoulder impingement/bursitis, and left shoulder partial rotator cuff tear. The treatment plan recommends a second request for right shoulder arthroscopic surgery, a request for authorization for a medical consult for pre-operative clearance, a request for authorization for ice therapy for post op pain and swelling x 6 weeks, a request for authorization for chiropractic therapy post op for the right shoulder 2 times a week for 6 weeks, a prescription for Percocet 5-325mg #120, a prescription for Keflex 500mg #12, a prescription for Ambien 10 mg #30, and a prescription for Zofran 4 mg #30. Urine drug screen collected on July 16, 2014 was consistent for oxycodone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 5/325mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone/acetaminophen, Weaning of Medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120.

**Decision rationale:** Regarding the request for Percocet 5/325mg #120, California Pain Medical Treatment Guidelines state that Percocet is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. In light of the above issues, the currently requested Percocet 5/325mg #120 is not medically necessary.

**Keflex 500mg #12:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clinical Practice Guidelines by the Infectious Diseases Society of America

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Cellulitis treatment

**Decision rationale:** Regarding the request for Keflex 500mg #12, California MTUS and ACOEM do not contain criteria for antibiotic treatment for this condition. ODG states that cellulitis treatment is recommended for bacterial skin infections. Within the documentation available for review, there is no indication that the patient has cellulitis, or any other sort of post-operative infection. In the absence of such documentation, the currently requested Keflex 500mg #12 is not medically necessary.

**Ambien 10mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sleep Medication

**Decision rationale:** Regarding the request for Ambien 10mg #30, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Ambien treatment. Additionally, a recent progress note indicates that the patient discontinued the use of Ambien. Finally, there is no indication that Ambien is being used for short-term use as recommended by guidelines. In the absence of such documentation, the currently requested Ambien 10mg #30 is not medically necessary.

**Zofran 4mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ondansetron, Antiemetics (for opioid nausea)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Antiemetics

**Decision rationale:** Regarding the request for Zofran 4mg #30, California MTUS guidelines do not contain criteria regarding the use of antiemetic medication. ODG states that anti-emetics are not recommended for nausea and vomiting secondary to chronic opioid use. Guidelines go on to recommend that Zofran is approved for post-operative use, nausea and vomiting secondary to chemotherapy, and acute use for gastroenteritis. Within the documentation available for review, there is no indication that the patient has nausea as a result of any of these diagnoses. Additionally, there are no subjective complaints of nausea in any of the recent progress reports provided for review. In the absence of clarity regarding those issues, the currently requested Zofran 4mg #30 is not medically necessary.