

Case Number:	CM15-0003399		
Date Assigned:	01/14/2015	Date of Injury:	04/13/1993
Decision Date:	04/10/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/07/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 with an industrial injury dated 04/13/93. He was being treated for right shoulder, neck, left knee, and low back pain, bilateral lower extremity weakness, paralysis secondary to spinal cord infarction/paraplegia. He was diagnosed with right shoulder impingement syndrome. The 12/4/14 treating physician report indicated that pain medications, including buprenorphine 10 mg patch per week and two Norco 10 mg tablets a day, were helping him tolerate his shoulder, low back and leg pain. The 12/9/14 orthopedic report cited limitation in shoulder abduction to 90 degrees active and 120 degrees passive, with loss in internal and external rotation. There was rotator cuff weakness and tenderness, and acromioclavicular joint and biceps tenderness. Cross body test was positive. A request for right shoulder arthroscopy with distal clavicle excision was submitted. Post-operative medications were requested to include Percocet 10/325 mg #90, and Oxycontin 10/325 mg #28. On 12/30/2014, Utilization Review certified the request for surgery, including the request for Percocet. The request for Oxycontin 10/325 # 28 was denied, noting a request for Percocet was certified within this review for post-operative use. An additional prescription for Oxycontin was not felt to be necessary. ACOEM Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Oxycontin 10/325mg #28: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Oxycodone Page(s): 76-80, 97.

Decision rationale: The California MTUS guidelines indicate that Oxycontin was a controlled release formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Oxycontin is not indicated for use as an as needed analgesic. Guideline criteria have not been met. There is no indication that this patient would require around-the-clock analgesia, beyond his current level of pain medications. A request for an as needed opioid medication (Percocet 10/325 mg #90) was found to be medically necessary for post-operative pain. There is no compelling reason to support the medical necessity of an additional opioid for pain management in the post-operative period. Therefore, this request is not medically necessary.