

Case Number:	CM15-0131207		
Date Assigned:	07/17/2015	Date of Injury:	01/15/2013
Decision Date:	09/17/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/07/2015

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: California
 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 53 year old female, who sustained an industrial injury on 01/15/2013. The injured worker is currently temporarily totally disabled. The injured worker is currently diagnosed as having chronic right shoulder pain with history of rotator cuff repair, right DeQuervain's tenosynovitis, and depression secondary to chronic pain. Treatment and diagnostics to date has included prior right rotator cuff repair on 12/04/2013, status post right carpal tunnel release, right DeQuervain's release, and right ganglion cyt excision on 04/23/2015, right shoulder cortisone injections, physical therapy, and medications. In a progress note dated 06/18/2015, the injured worker presented with complaints of lower backache and states pain level has increased since last visit. Pain is rated 7/10 with medications on a scale of 1 to 10 and 10/10 without medications. Objective findings include normal gait, limited movement to right shoulder with tenderness, and tenderness to right wrist and hand. The treating physician reported requesting authorization for Percocet and trial of Pennsaid solution for shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg Tab SIG 1 QID PRN #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82.

Decision rationale: The requested Percocet 10/325mg Tab SIG 1 QID PRN #120, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has complaints of lower backache and states pain level has increased since last visit. Pain is rated 7/10 with medications on a scale of 1 to 10 and 10/10 without medications. Objective findings include normal gait, limited movement to right shoulder with tenderness, and tenderness to right wrist and hand. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Percocet 10/325mg Tab SIG 1 QID PRN #120 is not medically necessary.

Pennsaid 1.5% Solution SIG 1 BID #2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Online Edition, 2015, Pain, Pennsaid.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents, Page 111-112; Non-steroidal anti-inflammatory medications, GI symptoms and cardiovascular risk, Page 68-69.

Decision rationale: The requested Pennsaid 1.5% Solution SIG 1 BID #2 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Topical Analgesics, non-steroidal anti-inflammatory agents, Page 111-112, recommend topical analgesics with documented osteoarthritis with intolerance to oral anti-inflammatory agents; Non-steroidal anti-inflammatory medications, GI symptoms and cardiovascular risk, Page 68-69, note that all NSAIDs have the potential to raise blood pressure in susceptible patients. The injured worker has complaints of lower backache and states pain level has increased since last visit. Pain is rated 7/10 with medications on a scale of 1 to 10 and 10/10 without medications. Objective findings include normal gait, limited movement to right shoulder with tenderness, and tenderness to right wrist and hand. The treating physician has not documented the patient's intolerance of these or similar medications to be taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Pennsaid 1.5% Solution SIG 1 BID #2 is not medically necessary.