

<b>Case Number:</b>	CM15-0166875		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	07/01/2011
<b>Decision Date:</b>	10/06/2015	<b>UR Denial Date:</b>	08/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2015

### 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: New York

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease

### 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 48-year-old male, who sustained an industrial injury on July 1, 2011. The injured worker was diagnosed as having traumatic arthropathy of shoulder region, other disorders of the shoulder region and traumatic brain injury. Treatment to date has included medication. A progress note dated July 14, 2015 provides the injured worker complains of gastrointestinal (GI) irregularity and irritability and left shoulder pain rated 10 out of 10 without medication and 4-5 out of 10 with medication. Physical exam notes left shoulder guarding, audible pop with shrugging, decreased strength and range of motion (ROM) is listed as unchanged. The plan includes medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg every six hours as needed quantity 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 Page(s): 78 - 79.

**Decision rationale:** The patient is a 48-year-old male with an injury on 07/01/2011. He had a shoulder and traumatic brain injury. On 07/14/2015, he had left shoulder guarding, decreased strength and decreased range of motion. MTUS, chronic pain guidelines for continued treatment with opiates require objective documentation of improved functionality with respect to the ability to do activities of daily living or work and monitoring for efficacy, adverse effects and abnormal drug seeking behavior. The documentation provided for review does not meet these criteria. This request is not medically necessary.